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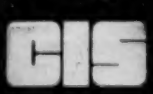

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CATASTROPHIC HEALTH INSURANCE: THE MEDIGAP CRISIS

HEARING

BEFORE THE

SUBCOMMITTEE ON
HEALTH AND LONG-TERM CARE

OF THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

SECOND SESSION

JUNE 25, 1986

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CATASTROPHIC HEALTH INSURANCE: THE MEDIGAP CRISIS

WEDNESDAY, JUNE 25, 1986

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON AGING,
SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:15 a.m., in room 2261, Rayburn House Office Building, Hon. Claude Pepper (chairman of the subcommittee) presiding.

Members present: Representatives Pepper, Biaggi, Vento, Wyden, Regula, Wortley, and Schneider.

Staff present: Kathleen Gardner Cravedi, staff director; Melanie Modlin, assistant staff director; Peter Reinecke, research director; Ronald Schwartz and Ronald Scheid, detailees; Chin Fa Chen, William Schloss, Laura Hart and Martin Schaeffer, interns; Mark Benedict, minority staff director; and Patrick McCarthy, minority professional staff.

OPENING STATEMENT OF CHAIRMAN CLAUDE PEPPER

Mr. PEPPER. Ladies and gentlemen, I am sorry, we had to go back over to the floor and vote and, therefore, delayed the session just a little bit.

Sometimes when I am late for a speaking engagement, I tell a story about back in the old days, in the South they used to have dueling. Two fellows became bitter enemies and one of them challenged the other one to a duel. They agreed on pistols as a weapon and a certain time and place for the duel. The time had almost arrived at the appointed place for the duel to begin. One fellow was there with his pistol and his second; the other man had not arrived. But just before time for the duel to begin, a messenger rushed up and handed a note to the duelist who was there from the one who hadn't arrived. The note read, "I am going to be late, go ahead and shoot."

Today we have a very important hearing. It deals with the abuses that have been inflicted on so many of the elderly people of our country by ambitious and sometimes avaricious insurance agents, sometimes aided and abetted by the insurance company for which that individual works.

In 1978, we had a hearing—the Aging Committee did—upon that subject, what we call Medigap insurance. The elderly people are very much aware of the fact that they are three times more liable to illness and, therefore, have three times the greater likely need

of medical care than younger people. They all fear the time when they might have to be put in a nursing home or have to have long-term care for their protection, and naturally they want to provide for that kind of care. They want to provide in such a way that their children or their loved ones will not have to bear the burden of their care. They are, therefore, what you might call the attractive subjects for those who would take advantage of this concern on the part of these elderly people.

So, sometimes, some of these companies—now, I am talking primarily not about insurance companies that write group insurance. Generally they are not guilty of these things of which we are going to be hearing here today. I am talking primarily about smaller insurance companies, generally. In some instances, and we have proof of it, the companies themselves train their representatives to make a presentation that will defraud, and that will include misrepresentation—taking advantage of an elderly person.

We have—you see here today a report. This subcommittee, through our able staff, has conducted a survey of 12,000 elderly people in the country. Of those 12,000 people, 90 percent of them said, in response to this inquiry, that they wanted to provide long-term care for themselves and they thought that Medicare plus these insurance policies that they were buying generally would protect them when they needed long-term nursing home or other long-term care.

We had one instance—you will hear about it today—where a man took over the management of the estate of an elderly relative and found that that elderly relative had bought 27 of these insurance policies which that individual thought would assure her of protection in case she needed long-term care. The unhappy, tragic fact was that not one of those 27 policies that she had bought and paid for with a large sum of money provided the long-term care that she thought she had assured for herself in her latter years.

So this is a very grave matter. We find many instances where these abuses have been inflicted upon the elderly people.

Now, the President, in his last address to the Congress, called upon the Department of Health and Human Services to make a study or survey of providing protection to the elderly people so they wouldn't be impoverished by the necessity of providing for that long-term care.

Incidentally, there is a study that was made in Massachusetts where 1,000 people were examined and they found that 46 percent of those people within 2 or 3 months become impoverished, destitute, having to pay for long-term care not covered by an insurance policy or by Medicare; others would become impoverished in a little longer period, maybe up to a year.

So, the President said that he wanted the Department of Health and Human Services to make a study of how protection could be given to the elderly people against catastrophic illness and catastrophic experience that would be ruinous to those individuals.

We were gratified when we read in the paper that Dr. Bowen, the distinguished Secretary of Health and Human Services, announced that he was going to propose a comprehensive catastrophic coverage program for the elderly. We got in touch with Dr. Bowen and invited him to come and testify before this subcommit-

tee. He was gracious enough to do so. But when he came we advised Dr. Bowen that according to the study of our able staff his proposal would cover only one-tenth of 1 percent of the elderly people, namely, only those who stayed in a hospital over 2 months. Of course, there is a need for coverage of that kind of hospital care, which is not covered generally by Medicare. But, as I said, that covered only one-tenth of 1 percent of the people and, of course, has nothing to do with long-term care and protection against some other excessive costs that some elderly people have to bear.

So I have introduced, with the support of my distinguished colleague here, Mr. Wyden, and some others, legislation, H.R. 4287. This bill without any additional expense to the elderly, or without any additional contribution by the Government, more wisely using the funds that are now being spent, by the Government and by the elderly people, would, we think, if properly managed and handled, provide catastrophic coverage for every senior citizen covered by Medicare. In other words, the senior citizen pays on an average about $600 a year in addition to what benefits that individual receives from Medicare, because Medicare doesn't cover, for example, Alzheimer's disease and for many other things. It doesn't cover, for example, hearing aids, dental care, foot care, and many other kinds of illness as well as long-term care.

So, by the individual paying about $600 a year, which is the average, we think by funneling all those funds into the proper channels and seeing to it that they are wisely spent primarily through private providers with the oversight by the Government, we can give comprehensive catastrophic coverage to every senior citizen. They wouldn't have to buy medigap insurance. They would be covered. So we recommend consideration of our bill, H.R. 4287.

So today we are going to hear some outstanding witnesses after my friend and colleague has made his statement. We are going to hear outstanding witnesses who have been kind enough to come here today to give their testimony to alert the public to the need for the kind of protection that we are proposing.

May I add one other thing. Our first study was in 1978, when we revealed the existence of these abuses to elderly people all over the country. In 1980, Congress passed legislation designed to protect the elderly against those abuses dealing with medigap insurance. We made it a felony to misrepresent the facts about that kind of insurance to these elderly people who were often so gullible under the pressure of necessity and the fear of need through these kinds of presentations.

Another provision of that 1980 law was that the Health and Human Services Department would report periodically to the Congress as to what progress was being made by the States in protecting the elderly against this kind of fraud. They haven't yet filed that report, although I understand from the staff that a copy of it can be bought through a subsidiary in California for $35. When we inquired of them, why haven't you fulfilled the law by filing your report with the Congress, they said the paperwork was too burdensome and they hadn't been able to get it ready. That is 4, 5, 6 years ago. The law was passed in 1980 and they should have had that report in the hands of the Congress a long time ago.

So this is going to be a very meaningful hearing today and we are very grateful to all of you here.

Now may I introduce one of the fine Members of this Congress of the United States, a man truly sensitive to the needs of all, particularly the elderly, my distinguished colleague and friend, the Honorable Ron Wyden.

[The prepared statement of Mr. Pepper follows:]

PREPARED STATEMENT OF CHAIRMAN CLAUDE PEPPER

MEMBERS OF THE SUBCOMMITTEE. LADIES AND GENTLEMEN. TODAY'S HEARING IS TREMENDOUSLY IMPORANT. IT COMES AT A TIME WHEN THE CONGRESS AND THE ADMINISTRATION ARE LOOKING FOR WAYS TO REMEDY THE ANTICIPATED SOLVENCY PROBLEMS FACING MEDICARE. IT COMES AT A TIME WHEN WE ARE TRYING TO IMPROVE MEDICARE'S COVERAGE FOR SENIORS. AS WE ATTEMPT TO ACCOMPLISH THESE NOBLE OBJECTIVES, IT IS IMPERATIVE THAT WE FIRST SCRUTINIZE THE ADEQUACY AND EFFECTIVENESS OF HEALTH INSURANCE CURRENTLY AVAILABLE TO OUR NATION'S 28 MILLION SENIOR CITIZENS.

MEDICARE HAS INCREASED DRAMATICALLY SINCE ITS ENACTMENT IN 1965 -- ALMOST 3600%. SADLY, IT HAS ALSO RIPPED GIANT HOLES IN THE FIXED INCOMES OF OLDER AMERICANS WHO HAVE NOT KEPT PACE WITH THE RISING HEALTH CARE COSTS. SENIOR CITIZENS TODAY ARE SPENDING MORE OF THEIR INCOME FOR HEALTH CARE THAN BEFORE MEDICARE WAS ENACTED.

COUPLED WITH THE INCREASED COST OF SERVICES COVERED BY MEDICARE ARE THE BANKRUPTING COSTS ASSOCIATED WITH SERVICES NOT COVERED BY MEDICARE OR MOST PRIVATE INSURANCE FOR THAT MATTER. MOST SENIOR CITIZENS DON'T REALIZE THAT MEDICARE AND PRIVATE INSURANCE DON'T PAY FOR CUSTODIAL NURSING HOME CARE OR HOME CARE FOR AN ALZHEIMER'S VICTIM OR MANY FORMS OF LONG-TERM ILLNESS. ALSO UNCOVERED ARE EXPENSES ASSOCIATED WITH HEARING CARE, EYE CARE, DENTAL CARE AND OUT-OF-HOSPITAL PRESCRIPTION DRUGS. TO TEST THE KNOWLEDGE SENIOR CITIZENS HAVE REGARDING HEALTH INSURANCE COVERAGE, I SENT A LETTER TO ALL 670 AREA AGENCIES ON AGING THROUGHOUT THE UNITED STATES. THEY EACH IN TURN SURVEYED AT LEAST 20 SENIOR CITIZENS IN THEIR COMMUNITY SENIOR CENTER. IN ONE MONTH, OVER 9,000 RESPONSES POURED INTO THE SUBCOMMITTEE DETAILING THAT 90% OF ALL THE SENIORS SURVEYED FELT THAT MEDICARE AND SUPPLEMENTAL INSURANCE WOULD COVER LONG-TERM CARE IN A NURSING HOME OR IN THEIR HOME. THE FACT IS THAT MEDICARE AND PRIVATE INSURANCE DO NOT COVER SUCH COSTS.

DOZENS OF HEARINGS BY THIS SUBCOMMITTEE REAFFIRM THE CONCLUSION THAT OLDER AMERICANS WILL DO ANYTHING RATHER THAN GO ON WELFARE. THE PURCHASE OF MEDICARE SUPPLEMENTAL INSURANCE SEEMS TO BE THE ONLY ANSWER. IT IS WISDOM THAT MOTIVATES MANY SENIORS TO PURCHASE ONE MEDIGAP POLICY. IT IS FEAR THAT PROMPTS THEM TO PURCHASE MORE THAN THEY NEED OR CAN AFFORD. THE SIMPLE FACT IS THAT TODAY NO POLICY COVERS ALL OF MEDICARE'S GAPS.

YOU WOULD THINK THAT OUR COMMITTEE'S WIDELY PUBLICIZED INVESTIGATION IN 1978 OF ABUSES IN THE SALE OF MEDICARE SUPPLEMENTAL INSURANCE TO THE ELDERLY AND THE CORRECTIVE LEGISLATION WHICH FOLLOWED IN 1980 WOULD HAVE BROUGHT AN END TO INSURANCE ABUSES. THIS HAS NOT BEEN THE CASE. THE RESULTS OF AN EIGHT-YEAR INVESTIGATION WHICH I WILL RELEASE IN A REPORT TODAY, DOCUMENT THAT WIDESPREAD MISREPRESENTATION OF POLICIES IS A FREQUENT OCCURENCE, THAT HIGH-PRESSURE SCARE TACTICS FREQUENTLY ACCOMPANY A SALES PRESENTATION, THAT AGENTS ARE STILL POSING AS FEDERAL EMPLOYEES TO MAKE A SALE, THAT AGENTS ARE PERSUADING ELDERLY PERSONS TO REPLACE ADEQUATE POLICIES WITH NEW ONES JUST SO THAT HE OR SHE CAN GET A HIGHER COMMISSION, AND THAT SOME COMPANIES ARE PAYING OUT VERY LITTLE IN BENEFITS IN COMPARISON TO WHAT THEY COLLECT IN PREMIUMS.

WE SURVEYED ALL 50 STATE DEPARTMENTS OF INSURANCE IN 1984 AND IN 1986. IN ADDITION, WE SURVEYED THE FEDERAL TRADE COMMISSION, THE JUSTICE DEPARTMENT, THE DEPARTMENT OF HEALTH AND HUMAN SERVICES AND THE U.S. POSTAL SERVICE -- ALL OF WHOM HAVE REGULATORY AND/OR ENFORCEMENT AUTHORITY OVER THE SALE OF HEALTH INSURANCE TO THE ELDERLY. WE FOUND THAT, WITH THE EXCEPTION OF THE U.S. POSTAL SERVICE, THE 1980 REFORM LEGISLATION HAS BEEN OF LITTLE VALUE BECAUSE IT HAS NOT BEEN ENFORCED.

THE STATES AND THE FEDERAL GOVERNMENT ARE NOT DOING AN ADEQUATE JOB OF PROTECTING SENIOR CITIZENS AGAINST UNSCRUPULOUS AGENTS WHO WOULD SEEK TO TAKE ADVANTAGE OF THEM. THIS FACT IS PARTICULARLY SERIOUS IN VIEW OF THE NEAR UNANIMOUS CONCLUSION FROM THE STATES THAT ABUSES PERSIST. THE ELDERLY TODAY ARE NO BETTER OFF THAN THEY WERE IN 1978. THE ONLY DIFFERENCE IS THE AMOUNT OF MONEY THAT SENIORS WILL WASTE TO INSURANCE RIPOFFS. IN 1978, THE SUBCOMMITTEE FOUND THAT ONE OUT OF EVERY FOUR DOLLARS SPENT FOR MEDIGAP INSURANCE BY THE ELDERLY WAS WASTED -- ABOUT $1 BILLION. TODAY, $3 BILLION IS WASTED BY OLDER AMERICANS.

THE SUBCOMMITTEE FOUND THAT THERE ARE FEW PROBLEMS PRESENTED BY THE INSURANCE HELD UNDER BLUE CROSS OR THE REPUTABLE COMMERCIAL COMPANIES DOING GROUP BUSINESS. THE PROBLEM LIES WITH THE MONEY SPENT BY SENIORS ON POLICIES PURCHASED ON AN INDIVIDUAL BASIS.

TO TEST OUR FINDINGS, THE SUBCOMMITTEE RECRUITED THE SERVICES OF A SENIOR CITIZEN INVESTIGATOR, MRS. LILLIAN SIMMONS. SHE IS A 68-YEAR-OLD WIDOW RECENTLY RELOCATED TO VIRGINIA. SHE HAS MEDICARE PARTS A AND B AND A SUPPLEMENTAL POLICY FROM THE AMERICAN ASSOCIATION OF RETIRED PERSONS. GIVEN HER FINANCIAL MEANS, SHE WAS DETERMINED BY INSURANCE EXPERTS TO BE ADEQUATELY COVERED. IF AN AGENT WERE TO RECOMMEND THAT SHE BUY ADDITIONAL OR DIFFERENT INSURANCE -- IT WOULD HAVE TO BE FOR MORE COMPREHENSIVE INSURANCE COVERAGE FOR ESSENTIALLY THE SAME PRICE.

MRS. SIMMONS MET WITH A DOZEN DIFFERENT AGENTS FROM DIFFERENT COMPANIES IN THE DISTRICT OF COLUMBIA, VIRGINIA, AND MARYLAND IN AN EFFORT TO DETERMINE WHETHER SHE WAS ADEQUATELY COVERED. AT ALL TIMES, ANOTHER MEMBER OF THE STAFF WAS PRESENT. ONLY ONE AGENT DID THE HONEST THING TELLING HER SHE WAS ADEQUATELY COVERED. OTHERS RECOMMENDED SHE KEEP HER POLICY AND BUY THEIR POLICY -- LEAVING HER WITH TWO POLICIES AND TWO PREMIUM PAYMENTS WHEN ONLY ONE POLICY WOULD COVER. OTHERS TOLD HER TO DROP HER POLICY BECAUSE IT WASN'T INSURANCE AND TO TAKE THEIR POLICY ALL OF WHICH COST SUBSTANTIALLY MORE THAN HER AARP PLAN -- IN ONE INSTANCE, 400% MORE. SHE TOLD ME, "IF A SECOND OPINION IS ADVISABLE IN MEDICAL CIRCLES -- THAT PRINCIPLE CERTAINLY DOESN'T APPLY TO INSURANCE BECAUSE I GOT TWELVE DIFFERENT OPINIONS."

WE WILL ALSO HEAR FROM A PANEL OF INDIVIDUALS WHO WILL DETAIL THE ABUSES THEY ENCOUNTERED IN THE PURCHASE OF MEDICARE SUPPLEMENTAL INSURANCE. WE ARE HOPEFUL THAT YOUR UNFORTUNATE EXPERIENCES WILL HELP BRING AN END TO SUCH ABUSE.

NOTED INSURANCE EXPERTS AND CONSUMER ADVOCATES WILL DISCUSS THE LATEST ABUSIVE SALES TECHNIQUES, COMMON MISREPRESENTATIONS MADE TO ELDERLY CONSUMERS, AND THE CONFUSION WHICH PERSISTS IN THE PURCHASE OF SUCH VITAL HEALTH COVERAGE. WE WILL ALSO HEAR FROM THE HONORABLE HUBERT H. HUMPHREY, III -- THE SON OF MY FORMER DISTINGUISHED SENATE COLLEAGUE AND VICE-PRESIDENT. AS THE ATTORNEY GENERAL FROM MINNESOTA, HE WILL SHARE HIS PERCEPTION OF ENFORCEMENT PROBLEMS WHICH PERSIST IN THE SALE OF MEDIGAP INSURANCE. THE MASSACHUSETTS COMMISSIONER OF INSURANCE WILL SHED ADDITIONAL LIGHT ON WHAT THE STATES MIGHT DO TO CURB THE INCIDENCE OF SUCH ABUSE.

I WAS LOOKING FORWARD TO HEARING FROM THE DEPARTMENT OF HEALTH AND HUMAN SERVICES -- THE AGENCY PRIMARILY REPONSIBLE FOR IMPLEMENTING AND OVERSEEING THE VOLUNTARY CERTIFICATION PROGRAM AND CRIMINAL PENALTIES ESTABLISHED BY THE 1980 REFORM LEGISLATION. THEY HAVE DECLINED TO TESTIFY. THIS COMES AS NO SURPRISE TO THE SUBCOMMITTEE. TO SAY THEY HAVE DONE A POOR JOB OF ENFORCING THE 1980 LEGISLATION WOULD BE AN UNDERSTATEMENT. THEY WERE REQUIRED TO SUBMIT TO THE CONGRESS 2 REPORTS ON STATE APPROACHES TO REGULATE MEDIGAP INSURANCE. THEY WERE REQUIRED TO REPORT ON THE EFFECTIVENESS OF THE VOLUNTARY CERTIFICATION PROGRAM AND THE CRIMINAL PENALTIES REQUIRED BY THAT LAW. TO DATE, THEY HAVE COMPLIED WITH NEITHER CONGRESSIONAL MANDATE. TO DATE, NOT ONE MEDICARE POLICY HAS BEEN FEDERALLY CERTIFIED. AND TO ADD INSULT TO INJURY, I AM TOLD THAT ONE CAN PURCHASE ONE REPORT MANDATED BY CONGRESS FROM THE RESEARCH GROUP IN CALIFORNIA UNDER CONTRACT WITH THE HEALTH CARE FINANCING ADMINISTRATION. FOR $35 YOU CAN GET A COPY OF THE REPORT THAT THE CONGRESS HAS YET TO SEE.

THE FEDERAL TRADE COMMISSION HAS THE RESPONSIBILITY FOR REVIEWING ACTIVITIES RELATING TO DECEPTIVE TRADE AND SALES PRACTICES IN THE SALE OF MEDIGAP INSURANCE. THEY WERE ASKED TO TESTIFY TODAY. THE FTC DECLINED INDICATING TO THE SUBCOMMITTEE THEY TOO HAVE ABANDONNED THEIR CONSUMER PROTECTION IN THIS AREA.

ALSO, THE INSPECTOR GENERAL OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES AND THE DEPARTMENT OF JUSTICE DECLINED INVITATIONS TO TESTIFY. THEY SHARE RESPONSIBILITY FOR ENFORCING VIOLATIONS OF CERTAIN ABUSIVE PRACTICES UNDER THE 1980 REFORM BILL. THEY HAVE DONE ESSENTIALLY NOTHING PROACTIVE IN THIS AREA.

ONLY THE U.S. POSTAL SERVICE, WHO WE WILL HEAR FROM TODAY, HAS NOT TURNED ITS BACK ON THE ELDERLY CONSUMER SEEKING PROTECTION AGAINST INSURANCE ABUSES. THE CHIEF POSTAL INSPECTOR WILL DETAIL THE POSTAL SERVICE'S EFFORTS TO INVESTIGATE ABUSES WHICH OCCUR NATIONALLY.

THE SUBCOMMITTEE CONCLUDED THAT THE 1980 REFORM LEGISLATION HAS BEEN OF LITTLE VALUE BECAUSE IT HAS NOT BEEN ENFORCED. THAT FACT IS PARTICULARLY SERIOUS IN VIEW OF THE NEAR UNANIMOUS CONCLUSION FROM THE STATES THAT ABUSES PERSIST. THE ELDERLY TODAY ARE NO BETTER OFF THAN IN 1978. THEY ARE STILL SEEKING TO PURCHASE HOPE, HEALTH AND SECURITY AND ARE LEFT WITH EMPTY POCKETS AND FURTHER DISILLUSIONMENT. THAT THESE PRACTICES HAVE GONE UNCHECKED FOR THE PAST EIGHT YEARS IS A NATIONAL SCANDAL ONLY SLIGHTLY LESS IN MAGNITUDE THAN THE SCHEMES OF THE AGENTS WHO PERPETRATE THE INSURANCE ABUSE.

STATEMENT OF REPRESENTATIVE RON WYDEN

Mr. WYDEN. Mr. Chairman, thank you very much. I am going to be very brief because you have said it so very, very well, Mr. Chairman, and certainly I think your bill is really headed in the right direction.

There are just a couple of points that I would make, Mr. Chairman. After the Pepper legislation of 1980, and after all the efforts by the States, the fact of the matter is that there are still a lot of Medicare supplements out there being sold to senior citizens that are not worth more than the paper that they are written on. That is why we are here today. We are here to try and make another effort to clean up the abuses.

I would like to just mention a couple of very serious problems that we are dealing with now. First are the television pitchmen who are selling insurance to senior citizens. All the evidence indicates that there is a great gap between what they say on television the policy will do, and what the policy ends up doing.

I think we have really got to go after these TV pitchmen who are selling scam Medicare supplements to the elderly of this country.

The second abuse that concerns me, Mr. Chairman, is the fact that some of these scam artists design their policies so that it looks just like a form from the Government. It looks just exactly like a form from Medicare and a lot of the older people think that the private company offering is something that the Government is really urging them to buy. I think we have got to take steps so that these private companies can't give the impression to older people in this country that they are involved in something that has the Government sanction and the Government approval.

Another point that concerns me, Mr. Chairman, is that the 1980 legislation doesn't take into consideration the new system for paying hospitals, the DRG system. The DRG system that was passed in 1983 reduces the need for supplemental part A coverage. The reason is that no hospital can charge a patient for amounts over the specified DRG rate. But the 1980 legislation, the Pepper legislation, could not have taken DRG's into consideration. So we still have a lot of senior citizens being taken advantage of, being sold these supplements for a hospital kind of coverage that the DRG system has reduced very markedly.

Mr. Chairman, I think that really hits the concerns I have. My staff, too, called the Health Financing Administration yesterday and asked why they couldn't get the report out. As far as I can tell, it is just simple footdragging. And you wonder what the report has in it which the administration seems reluctant to get out. I think the thing we are forced to suspect, because we haven't seen it, is that the report indicates that a lot of the kind of practices that I mentioned and that you mentioned are still going on.

The last point that I would bring up, Mr. Chairman, is you sent me this wonderful letter when I got elected to Congress in 1980. In the letter, which is up on my wall, Mr. Chairman, you talked about when I was director of the Gray Panthers of Oregon, I came back here to testify before you in the late 1970's to try to clean up this problem. It just struck me as I looked at this wonderful letter from you, Mr. Chairman, that we have a lot of additional work to do. I

can just tell you that I am looking forward to being a cosponsor of the next Pepper effort to clean up problems of the TV situation, the policies that look like Government forms, and the DRG problem. When you go forward with your next effort I am going to be there.

Mr. PEPPER. Thank you very much, Mr. Wyden. You are one of the men who has lived up to the commitment you made to your people and to the elderly people that you were going to be their champion. You have been one of the best friends they have ever had here in the Congress of the United States. And all of us who are of that mind have got a lot to accomplish, and I am sure we are going to get a lot of that done with the talent and energy of persons like yourself.

Miss Schneider, we are delighted to have you. Would you like to make a statement?

Miss SCHNEIDER. Thank you, Mr. Chairman.

I think that my colleague very articulately stressed the specific points that I am anxious to get some responses to today, so I am not going to be duplicative. I am most anxious to hear from your expert witnesses that we have gathered here today.

Mr. PEPPER. Thank you very much.

Now then, our witnesses today, our panel one: Medigap Abuse Victims and Consumer Advocates. Mr. Elmer Van Doren of Garfield, AR; Mrs. Lalah Welch of Oakton, VA; Frederick Schaefer of Wheaton, MD; Daffner Jones of Salisbury, NC; Lillian Simmons, Subcommittee Senior Citizens Investigator, of Arlington, VA.

I was on a TV program with CBS this morning and Mrs. Simmons made a very fine statement over that network.

David Horowitz, consumer commentator, syndicated columnist, host of "Fight Back," a nationally syndicated consumer affairs television program of Los Angeles; and Mr. Robert Hunter, president of National Insurance Consumers Organizations of Alexandria, VA.

We are delighted to have you here. I will call you according to the way I have them listed here on our program. First is Mr. Van Doren. Will you proceed, Mr. Van Doren?

PANEL ONE—MEDIGAP ABUSE VICTIMS AND CONSUMER ADVOCATES: CONSISTING OF ELMER VAN DOREN, GARFIELD, AR; LALAH WELCH, OAKTON, VA; FREDERICK C. SCHAEFER, WHEATON, MD; DAFFNER JONES, SALISBURY, NC; DAVID HOROWITZ, CONSUMER COMMENTATOR AND HOST OF "FIGHT BACK," SYNDICATED CONSUMER AFFAIRS TELEVISION PROGRAM, LOS ANGELES, CA; LILLIAN SIMMONS, SUBCOMMITTEE SENIOR CITIZEN INVESTIGATOR, ARLINGTON, VA; AND J. ROBERT HUNTER, PRESIDENT, NATIONAL INSURANCE CONSUMER ORGANIZATION, ALEXANDRIA, VA

STATEMENT OF ELMER VAN DOREN

Mr. VAN DOREN. Good morning, Mr. Chairman, ladies and gentlemen. My name is Elmer Van Doren and I am from Garfield, AR. I am here today to tell you of the experiences of my aunt, who has had many serious health problems and who, like many older Americans, thought the best way to protect herself was with the purchase of insurance to supplement Medicare. Keep in mind, she al-

ready had Medicare and Blue Cross/Blue Shield. Unfortunately, things got out of hand. She purchased 28 of these policies and they paid little or nothing to assist her with her expensive health care.

My aunt is now 88 years young. She is lucid and mobile and has a cheerful outlook. She is a survivor.

However, the last 6 years have been rocky ones. She has somehow hung on through surgical repair of a ruptured disc from a fall in her yard; fractured ribs and a fractured wrist and hand from several falls in her home; a colonectomy in 1984; and, 4 months ago, a mastectomy at 88 years of age. Last month, while still recovering from this, she suffered a broken hip. How is that for tough? Sixteen months ago she entered a nursing home.

Because my aunt lives in Illinois and I am in Arkansas, it has been difficult for me to keep apprised of her financial dealings. Her husband passed away 37 years ago and the sister with whom she was living entered a nursing home in 1978. She has really had to fend for herself. In my opinion, insurance fraud has been forced on this lady by more than one agent. Even the integrity and good name of several nationally known insurance companies may be—strike that—are in question.

In 1982, because my aunt had fractured four ribs, my wife and I went to Illinois to help her through her convalescence. She was pretty weak and couldn't care for herself too well. On December 20, 1982, my aunt granted me power of attorney. She then asked me to review her insurance policies to see that proper claims had been filed for her recent injuries. I was astonished by what I discovered.

She had what appeared to be 16 or so medigap policies—I could tell by piecing together such evidence as cancelled checks and notes she had written to herself. Several companies apparently hadn't even taken the time to send her a policy, although they had no hesitation about taking her money.

I was outraged, of course. In one case, four different policies had been sold to her from one company, and this is really an understatement. The premiums for all of her policies in 1982 alone came to $5,500, or almost $460 a month.

Of course, I could see that something was seriously wrong, so I decided to take action. The day after I was granted power of attorney, I sent all information relating to my aunt's insurance policies to the Illinois Department of Insurance, consumer services section. I was fortunate to have assigned to the case Mr. Jack Fisher. He doggedly investigated my aunt's policies and the companies that had sold them, and found evidence of much duplication of coverage and other shady dealings. After about 6 months of work, Mr. Fisher managed to have all 28 policies—her actual holdings—cancelled and/or payments refunded. $9,687.15 was returned to her, and that money is proving very helpful in paying for her long-term stay in a health care center.

My aunt was more fortunate than most. She had me to help try to untangle her many policies and to put up a fight. Mr. Fisher at the Department of Insurance worked to see that justice was done and restitution made.

My aunt is smart and capable. But, living alone and with her many ailments, I guess she was an easy mark for unscrupulous insurance agents. My aunt may have felt that policies which prom-

ised convalescence care in big print would provide her with long-term nursing home care.

Mr. Pepper, I am hopeful laws can be enacted that will outlaw this kind of insurance overloading and prevent other elderly people from going through what my aunt has had to go through.

Thank you.

Mr. PEPPER. That is a shocking and sad story. Imagine, nearly $10,000 they wrenched away from that lady.

Do you have, Mr. Van Doren, copies of any of those policies, by chance?

Mr. VAN DOREN. Yes, I do.

Mr. PEPPER. Would you mind leaving them with us and letting us look at them?

Mr. VAN DOREN. I certainly will, sir.

Mr. PEPPER. Thank you very much. We will examine them very carefully. We are glad you have them.

We will have questions when all of the panel have completed their statements.

Mr. PEPPER. Next is Mrs. Lalah Welch of Oakton, VA.

Mrs. Welch.

STATEMENT OF LALAH WELCH

Mrs. WELCH. Good morning, Mr. Chairman and members of the subcommittee. My name is Lalah Welch and I am from Oakton, VA. I am here this morning to share with you the tragic experiences of my 80-year-old sister and her 88-year-old husband who live in Sebring, FL.

This past February, I was visiting my sister and brother-in-law in Florida. During my stay, my brother-in-law, William, was hospitalized for internal bleeding caused by a stomach disorder. He was hospitalized 10 days, then transferred to a custodial care nursing home at the hospital's request.

After William entered the nursing home, my sister and I realized that he would probably spend his remaining years there. The symptoms of Alzheimer's disease were starting to creep up on him. Before he was institutionalized, my sister had been caring for him by herself. But with his stomach problems and the helplessness that he displayed with the Alzheimer's, it was becoming a tremendous strain for her to do so.

After William was put in the nursing home, I started helping my sister look after her medical bills. We also checked her supplemental Medicare insurance to determine what coverage she had. My sister is a dear but she has very limited knowledge of insurance. Because I had worked as an insurance underwriter for over 16 years, I gave her advice about insurance. A number of years earlier, I had helped her pick out a supplemental policy which I thought was pretty good.

When I got around to reviewing my sister and brother-in-law's medigap policies, I was shocked. They had dropped the policies I had recommended, which cost about $400 a year in premiums, and taken out new policies which cost over $1,900 a year. I decided to take a look at their new policies—maybe they were better—but the new policies provided almost identical coverage to their original

ones. The only significant difference was the cost—they paid four times the premium to maintain the new policies.

I was disappointed that, like the old policy, the new policies provided no coverage for custodial nursing care. That was the one benefit they really needed. My poor sister was shocked to hear this news. She told me that the insurance agent had persuaded her to switch to his policy by telling her his paid all expenses not paid by Medicare, including total nursing home coverage. My sister said she never would have changed policies unless she was sure all nursing home care was covered. This had always been her greatest fear—that a long-term, catastrophic illness would wipe out their life savings. You can imagine her emotional devastation when she learned that her husband's monthly nursing home bill would not be covered by her new and very expensive insurance policy.

I was angry at the treatment my sister had received at the hands of this insurance salesman, so I decided to go see him myself. We set up an appointment and he never showed up. After that, I kept trying to call him but he would be "out of town," or there would be no answer. I made an inquiry with the local Chamber of Commerce and learned that they had received several verbal complaints regarding the agent's activities. However, I guess he is still selling insurance to this day.

So far, my sister is managing to pay for her husband's nursing home expenses from their personal savings. She will soon have depleted their money, however, and will have to sell their home in Florida and the family farm in Virginia in order to meet the large monthly nursing home payments. Her financial future is bleak and I am afraid all she has to look forward to is life on public assistance.

They worked hard all their lives and were diligent in planning for their retirement. They thought it would be the happiest time of their lives. Now they find themselves close to financial and emotional ruin because of a catastrophic illness. Furthermore, they fit the pattern which is all too common—they are seniors who were besieged by insurance ads that promise the moon, and unscrupulous agents who prey on older people's fear of long-term illnesses. Either one of these can convince seniors to buy insurance which is overpriced and which doesn't provide the kind of coverage needed to cope with a catastrophic disease.

I have recently learned that my sister has sold their home in Sebring and moved to Cape Coral, FL, to be near their daughter. My sister has taken William out of the nursing home because she cannot afford to pay the monthly bill. I am fearful my sister will ruin her health trying to care for William.

I am deeply concerned about what my sister and her husband are going through. I hope that you will be able to pass legislation which will protect all Americans against the devastation of a catastrophic illness. No one else should have to go what they have gone through.

I thank you.

Mr. PEPPER. Thank you very much, Mrs. Welch, for the sad story that you have told us.

Mr. PEPPER. We have just now had one of the senior members of our subcommittee arrive, one of the outstanding members who has

been dedicated to the objectives of this committee for a long time. He and I have been on this committee a long time together; a great Member of the Congress, and a great friend, Hon. Mario Biaggi. Would you like to make any statements, Mr. Biaggi, before we proceed?

STATEMENT OF REPRESENTATIVE MARIO BIAGGI

Mr. BIAGGI. Thank you very much, Mr. Chairman.

The fact is you and I have been on this committee since it was organized. It has been my pleasure to serve with you. It has been said that history oftimes repeats itself, and it was almost 8 years ago when Chairman Pepper and I conducted a hearing into a developing scandal dealing with medigap policies. We learned how policies were returning less than 30 cents in benefits for every $1 paid in benefits.

This led to elderly consumers buying multiple policies, including one woman who had to sell her farm in order to pay her insurance premiums.

I recall sitting in with a prospective purchaser of a cancer policy with the bold warning emblazoned on the policy: Cancer will strike. The salesman was purporting this policy would provide coverage for a variety of services for a person struck down with cancer. What the salesman failed to indicate was that in order for that policy to pay off, a person had to be hospitalized. Not all cancer patients need to be. Yet, many purchase, unsuspecting, of how limited the policy really was.

We accomplished some reforms in the 1978 investigation. Yet, today we are back. Again, Claude Pepper is in the forefront of this campaign and problem. The Pepper report being released today will show that as much as $3 billion a year that seniors spend on so-called medigap policies will be lost to waste and abuse. Again, we find the menace of misrepresentation as a prime culprit. We find modern-day merchants exploiting misery to sell useless insurance policies. We see too many peddlers of false promises ripping off senior citizens. We find that while bureaucracy fiddles, senior citizens are being finagled.

The fact is the Health Care Financing Administration is 4½ years late in completing a study of State efforts to curb abuses by insurance salesman—a study critical to shaping improved Federal efforts.

Today in our Nation, three out of every four people over 65 are forced by medigap policies to cover what Medicare fails to do. Our reform strategy must be to either expand Medicare coverage or more closely monitor those who sell medigap policies. We do not want to read about seniors being victimized by insurance schemes which rob them of their life savings and return nothing on their investment.

To curb any illicit billion dollar industry, Congress has a compelling responsibility to act on the phony medigap industry which, according to the Pepper report, finds that senior citizens are being taken for as much as $1 billion a year in useless policies, bringing them to the state of financial ruin, frustration, desperation, which clearly impacts on their mental and physical well-being. It is more

than just dollars, you are talking in human terms, and that is what we must address.

The stories that we have heard in the past, I am sure will be replicated today, and the need of yesterday continues on today. The problem will never be fully solved until we have every level of government and every agency involved working with the kind of motivation and commitment that Senator Claude Pepper has.

Mr. PEPPER. Thank you very much, Mr. Biaggi, for your excellent statement.

Now we have another fine member of this subcommittee who has arrived, Mr. Wortley.

STATEMENT OF REPRESENTATIVE GEORGE C. WORTLEY

Mr. WORTLEY. Thank you, Mr. Chairman. I won't take up a great deal of time with an opening statement but I do want to commend the chairman for focusing in on this problem again today.

These are of vital interest to me because I happen to be one who lives with the problems of Medicare and medigap insurance problems. I happen to have a mother and a mother-in-law, both of whom are in extended care medical facilities, and probably will be there for the rest of their lives. I understand many of the day-to-day problems that are confronted by families who must look out for their parents and other relatives who are so dependent upon them.

Certainly, this insurance problem is one of the great, great burdens that all of us who have to look out for our parents and loved ones must come to grips with. There are many, many unscrupulous individuals out there who would take advantage of our older Americans and sell them policies that don't perform the services for which they were intended.

I, for one, salute Senator Pepper, the chairman of this committee, for calling this hearing today, inviting people here, and those from the industry and those from Government who can respond to some of the very serious concerns that this committee and the U.S. Congress has in the care of older Americans.

Thank you, Mr. Chairman.

Mr. PEPPER. Thank you, Mr Wortley.

The next witness will be Mr. Frederick Schaefer of Wheaton, MD. Mr. Schaefer?

STATEMENT OF FREDERICK C. SCHAEFER

Mr. SCHAEFER. Good morning, Mr. Chairman and members of your committee.

My name is Frederick Charles Schaefer. I am 78 years old and reside in Wheaton, MD. I am here today to share with you the sad events I have experienced as a result of my wife's health problems. I feel I am speaking not only for myself but for the millions of Americans who have had similar experiences already, and for those who will someday find themselves faced with the same financial and emotional devastation that I have experienced for the past two years.

Approximately 13 years ago, I retired from Pitney-Bowes Company after 31 years of service. My retirement income consists of a small pension from Pitney-Bowes plus Social Security benefits. My

wife Ruth, who is 79, is on Social Security. Both my wife and I have Medicare parts A and B.

When we retired, our house was paid for and it looked as though we had saved enough to enjoy our retirement years. At the very least, we felt financially secure.

As a safeguard against catastrophic illness, I decided my wife and I should both be covered by an insurance policy to supplement Medicare. The advertisements I saw on television and received in the mail convinced me that my wife and I could obtain all the protection we desired.

Unfortunately, I had little knowledge of health insurance then. The advertising material and the language of the policies themselves might as well have been in Greek. Nevertheless, I purchased five such policies, commonly referred to as "Medigap" policies. I paid over $1,200 a year in premiums for these policies. What I got for all that money was real peace of mind. I could rest easily knowing my wife and I had protected ourselves from any long-term catastrophic illness.

Then, in 1980, my world turned upside down. My wife was diagnosed as having Alzheimer's disease and Parkinson's disease. For the next 4 years I cared for my wife at home. During that time, her condition significantly deteriorated. She demanded the majority of my attention but I gladly gave it. Even though I was saving money by caring for my wife at home, the medical expenses caused a drain on our savings. In 1982, I was forced to sell our three-bedroom home and buy a one-bedroom condominium.

As my wife's illnesses continued to take their toll, and her physical mobility and mental alertness decreased, I had to maintain almost constant watch over her or, otherwise, she might injure herself.

On April 29, 1984—a date I will never forget—I left my wife unattended for only a few minutes. I subsequently found her lying on the bedroom floor with a broken hip and shoulder.

She had surgery to repair her hip and shoulder and after only 10 days, the hospital wanted to move her to a custodial care nursing home. Up until this time, I really hadn't thought much about the differences between custodial, intermediate and skilled care nursing homes. Furthermore, I had no serious concerns about the cost of any kind of nursing home care. I was certain my insurance policies would cover the expenses.

After her hospital stay, my wife was placed in a custodial care nursing home. As I said, I felt confident that the $12,000 I had paid out in insurance premiums over the past 10 years would protect us in this time of crisis. However, when I read the fine print contained in all five policies, I was horrified to learn that not one of them covered custodial nursing home care. Neither did Medicare.

So, in less than 2 years, I paid over $70,000 to the nursing home and our life savings were dwindling rapidly. To see my wife suffering so much from these dehumanizing diseases and to see our savings being eaten up at the same time caused me much emotional distress.

I finally found help and comfort at the Holiday Park Senior Center in Wheaton, MD. The support group I belong to is made up of seniors who have spouses suffering from a catastrophic illness.

Leaders of this group directed me to a medical assistance program operated by the Area Aging on Aging of Montgomery County. They informed me about a Maryland law that permits people in the position my wife and I are in to divide their assets in half. Thereafter, the funds of the sick spouse are used to pay his or her medical expenses. When these funds run out, he or she is free to apply for Medicaid. I did divide our assets in half several months ago. By May, my wife's funds were depleted and she went on Medicaid. Medicaid will cover her nursing home costs.

To be honest, it pains me very much to see my wife on Medicaid, but there was nothing else we could do. Several years ago I suffered a stroke which prevents me from working, so even if wanted to work to supplement our income, I couldn't.

Although I have bitter thoughts about what I have had to endure financially and emotionally, I still have one thing to be thankful for—I can visit my wife every day. I visit her daily at the nursing home between three and nine.

As for my financial status, about all I can say is that I can meet my monthly obligations, but it is not easy and I have to watch my expenditures very closely. Our "golden years of retirement" have not worked out as my wife and I planned.

It is unfortunate—almost criminal—that people are paying thousands of dollars like I did for insurance, which they are led to believe will take care of them when a catastrophe strikes—only to have that sad moment come and not have that promise fulfilled. Furthermore, the policies and related material are written in language which is difficult to understand, or gives one a false sense of security.

Mr. Chairman, I hope and pray that your subcommittee will come up with a solution to this national problem which is leaving many families emotionally and financially devastated.

Thank you.

Mr. PEPPER. Thank you very much, Mr. Schaefer. I wish everybody in America could hear every statement being made here today. It would break the heart of those who hear them and it would arouse the anger as well of those who see our fellow citizens imposed upon in such a manner.

Next is Mrs. Jones, Mrs. Daffner Jones, of Salisbury, NC. Mrs. Jones.

STATEMENT OF DAFFNER JONES

Mrs. JONES. Good morning, Mr. Chairman and distinguished members of the panel. My name is Daffner Jones and I have come from North Carolina to tell my story. I have tried to get help from many sources—I have even contacted President Reagan—but until now no one has answered my plea. There is a problem of epidemic proportions in this country today. Medicare is covering less and less and families are having to pay more and more for it. The private insurance companies' medigap policies don't shoulder much of the burden. When you need them the most, Medicare and medigap can leave you high and dry.

My 83-year-old mother has been sick for about five years with cerebral insufficiency or possible Alzheimer's disease plus numer-

ous other medical problems. She has been unable to walk since July of last year. And last year, from December 1984 until November, I had her at home. Seven admissions in that year—all with the same problem, except for one time—in July, she had, while she was in the hospital, she fell and had to have a total new replacement. Since July 1985, she has not walked except with help. After I kept her at home from July until November, and she had to have constant care 24 hours a day. I could get no help. I took care of her the last 10 days I had her at home. My family or I did not see a bed because it was 24 hours a day.

She was admitted back to the hospital and was there for 30 days. At this time, the doctor told us that we had to have skilled care. It took almost 15 to 20 days to find a bed and, of course, I had had precious Danny Thomas' policy that I would like to go on television and tell everybody, it is not what he does for you, it is what he doesn't do for you.

So, the hospital looked over my policy. The nursing home looked over the policy it would pay. Medicare says it will pay for skilled care. It doesn't pay for skilled care. If Medicare doesn't pay, your insurance doesn't pay.

She was in the nursing home. They accepted her on this policy. Three days later, they tell me it won't pay. Medicare is not going to pay, so you have to move her. At this time, there was no place to take my mother.

She also has a corroded artery and bowels in her heart that have blockages. She came with chest pain. She was moved back to the hospital because I had 24 hours to move her from the nursing home, and no place to go. So we took her back to the hospital with the chest pains. She was in the hospital 3 days before we found another bed to take her.

The PRO and DRG says no, we will not pay the bill. If Medicare doesn't pay the bill, and if your medigap policy doesn't pay—and, of course, by this time we had had to go on Medicaid, which is State paid.

If your insurance doesn't pay, Medicaid doesn't pay. So I have a bill facing me because she does not meet the criteria. After that, she was moved to a nursing home. In the meantime, she was at Clapp's Nursing Home in Asheboro, which she was admitted the fifth day of December in 1985—1986, wherever.

Anyway, at that time, when we thought that we were being covered—was not covered. The nursing home in turn has sued and gotten a judgment against me for a bill of $2,317.50 because I signed my mother's name. My mother was not able to sign her name. She doesn't even know which world she is in.

From there we have been down the road. And as a result of this hassle with the nursing home and the experience that I have had, through all of this we were keeping up her Medicare part of 15.50 for medical services. We were also diligently paying $33.58 a month for her medigap insurance, which has paid for an ambulance. And on one occasion it paid some of her doctor bills at the nursing home, but it didn't pay her nursing home bill.

I really thought that we had the health coverage for my mother. But neither the Government nor the private company would take care of the nursing home or these hospitalizations which my moth-

er's doctors had termed medically necessary. And, of course, she is now on Medicaid and still not paying the bills. Medicaid is not paying this last month. Of course, all of her income goes toward her support. I still end up with a $121, which I have with me, drug bill, plus $154 that I still owe the nursing home after Medicaid and her income which has gone to her care.

It is a sad day for our Nation's elderly when they have to go on Medicaid, when they have faithfully made Medicare payments and paid insurance premiums for years, expecting their last years to be lived out in peace. Instead, they are stripped of all their dignity and families are suffering the hardships.

I don't pretend to understand all the intricacies of health care and health policy—I will leave that to the experts. But I honestly thought that with Medicare and the medigap policy she would be taken care of. I didn't expect her to ever be rich, but I thought we would have enough to pay.

I am very hopeful that there might be a way to resolve the difficulty my mother has gone through, and to take care of these unpaid bills. I am not sure there is much we can do. But I beg and I plead with you to try and correct the system so that such illnesses as my mother has had, and the ones my husband and I now have, will be covered in the future. Something is desperately wrong.

And even our Bible tells us, we don't have a choice to take care of the elderly—we have a charge. We are charged to take care of the widows. And I think it is time our Government realizes this. We are striving for a place, and unless we can fulfill what God has tried to teach us, we are going to fall.

Thank you.

Mr. PEPPER. Thank you very much, Mrs. Jones, for your moving statement as well.

You know, you would be shocked, really, if you didn't know these things exist, to learn that they could exist in America. Somehow or another all of us together have got to got to work out some program under the principle of insurance, whereby we can insure our health, insure ourselves against catastrophic illness, and have assurance that we will really be protected when catastrophe strikes.

It is the goal of this committee to try to find a way to make the health care needed available to every man, woman, and child in America through some sort of an insurance program where they pay all they can, and should, and the care will be efficiently provided by competent providers to the people who need the care.

I mentioned awhile ago that we had Dr. Bowen, the Secretary of Health and Human Services, appear before our subcommittee. We called his attention to the fact that his proposal only covered one-tenth of 1 percent of the elderly people and provided no coverage whatsoever for long-term care.

We told him we were gratified and we commended him for embracing the principle of taking care of the catastrophic health needs and costs of elderly people. But would he not in his study try to determine how we can establish a plan that covers all catastrophes, all health needs, for all elderly people. He said he would.

Last week, I wrote a letter to the Chairman of the National Academy of Sciences, whom I had met at a dinner recently, and he

gave me encouragement to believe that his agency would make a study that I thought we needed in trying to fashion this kind of legislation. The study would tell how much it would cost to provide complete catastrophic coverage to every man and woman in the elderly group now in the United States.

And our bill, H.R. 4287, provides the elderly who are covered by Medicare with catastrophic coverage, comprehensive coverage. And in addition to that, it also provides the States the opportunity to purchase participation in that program by paying into the fund 90 percent of what it anticipates it would spend per Medicaid patient in the coming year. That would save money for the States, and, at the same time, it would provide the opportunity for that program to be administered along with these other programs in the most efficient way and by the best providers under the general supervision of the Government.

Mr. Regula, I am delighted to see you. Would you like to make a statement before we proceed?

Mr. REGULA. Thank you, Mr. Chairman. The issue of abuse in the purchase of Medicare supplemental insurance policies is a very important matter which requires constant review by both the State and Federal Governments. I am happy to join with you today in hearing testimony regarding the current status of such abuse and those effects being conducted to remove the threat.

It is well known that congressional studies conducted prior to the passage of section 1882 of the Social Security Act, studies which were pioneered by our subcommittee, found many abuses existing in the sale and marketing of medigap health insurance. Our concern focused on the level of benefits in relation to premiums, duplicative coverage, the complexity and difficulty of insurance terminology and other marketing abuses. Through concentrated and persistent efforts we were able to obtain the passage of the Baucus legislation which provides for Federal supervision of State certification of private insurance to correct these wrongs.

Today, the focus of this hearing will be whether the States and Federal Government are adequately enforcing this law. The Chairman states that approximately $1 billion, or $1 in every $4 spent on supplemental insurance, is spent annually on wasteful and unnecessary polices. Numerous anecdotes exist regarding the questionable marketing techniques used upon the elderly by insurance agents. However, a 1983 HCFA study of the effectiveness of State regulation of such insurance found that duplicative coverage was rare. Comments from leading experts with the National Association of Insurance Commissioners and individual State Commissioners indicate there is no greater instances of abuse here than in the sale of other types to insurance.

It would be premature to speculate on the severity of the problem with current data. I welcome the report and statistics compiled by the Chairman in his efforts to protect our Nation's elderly. There has been a conspicuous absence of data which must be secured. Earlier today, I was provided updated information by the Health Care Finance Administration regarding this matter. To answer the question whether current efforts are sufficient requires that we carefully examine the material brought before us in this hearing and our own independent investigations.

Another issue which is a part of this problem is the need for expanded medigap policies that include catastrophic and long-term care. I have been joined by a plurality of our minority members in introducing legislation which is aimed at developing appropriate private sector insurance. It is the nature of the private sector to structure products that are competitive and flexible to the changing needs of the consumer. By the use of certain Federal encouragements and restrictions our legislation will harness that ability and permit the insurance industry to provide for the long-term health care of all Americans.

Those agents who place personal profit, above the interests of their clients, must be sought out and removed from the system. If more than one incident of abuse occurs it is one too many. If current efforts are insufficient they will be improved. The existence of such an odious thing cannot be allowed to continue. I won't delay this but simply compliment you on having this hearing. We have been working on catastrophic legislation utilizing the private sector as well as the public from our research. On the minority side we find that there is a serious problem of duplicate coverage along with representations as to what coverage does when in fact it doesn't give what the purchasers think.

So I think it is important that we focus attention on that problem through a hearing of this type and hopefully we can address the difficulty that confronts those who purchase the insurance as well as providing a good long-term solution for the need for catastrophic care. The President, in his State of the Union message, mentioned this need, and I think there is a bipartisan agreement that we need to find some solution to ensure that senior citizens do have the protection they need and desire.

Thank you for the chance to outline this.

Mr. PEPPER. Thank you very much, Mr. Regula.

The next witness will be Mr. David Horowitz. He is a consumer commentator as I said a little bit ago. Mr. Horowitz, we are pleased to have you and we would be glad to hear you.

STATEMENT OF DAVID HOROWITZ

Mr. HOROWITZ. Thank you very much, Mr. Chairman.

First of all, I want to thank you for inviting me back to testify. We were together a couple of years ago. We talked about quack devices and some of the scams that the elderly were confronted with. Over the years, we have had the chance to highlight many of the different frauds and abuses that are perpetrated against older Americans.

I am proud to say that some of these uses have been controlled or have disappeared altogether when they were widely publicized. I hope through this hearing some of the medigap, or what I call medicrap abuses, will also disappear.

Unfortunately, as I listened to some of the victims who were testifying, I was struck by the lack of progress that we have achieved in protecting the elderly from the abuses of these supplemental Medicare policies. There are many, many of these policies that are available today and most of them with convoluted language even a legal scholar couldn't untangle. I would love to have some of the

members of the subcommittee sit and try to figure out what some of these policies say. They are very, very difficult to understand.

So, obviously for some of our senior citizens who are being sold a quick hype job on television or in a newspaper supplement or by some fast talking salesman, they are not going to look at the exclusions or question the exclusions they don't know are even there, and so after the policy is sold they find out as we found out some of the problems that are involved.

But the thing that really gets to me as a consumer person is the people who are the so-called pitchmen—some of them. You are looking at at our bulletin board here in the sample medigap policies that are obtained, or outlined. I mean, the Danny Thomases, the Lorne Greenes, and the Burl Ives, who I don't think are guilty of trying to perpetrate some sort of falsehood on the American public, but are being paid to sell these policies and are also being fooled the way many senior citizens are fooled into believing that these policies are actually going to help the people that they are selling them to.

Fortunately, for these people, they don't have to worry about medigap insurance because they can afford through other policies or through their livelihood to be able to pay those bills.

But if you buy medigap insurance the way they sell it, the feeling is that you will never ever have to worry about buying insurance again, to pick up the cost that Medicare doesn't pay. Now, for the sake of all the seniors who have testified here and for the senior citizens of America, obviously, I wish that were true. But, of course, my experience dictates the opposite.

Mr. Chairman, I know how hard you and the members of this subcommittee have worked on Medicare and for a comprehensive program to help senior citizens and provide some sort of catastrophic coverage for the diseases and the illnesses, the glasses, the false teeth, things that are not covered by Medicare. But, unfortunately, despite your valiant efforts, I fear that today they are still in the same shape that they have been for the last 10 years.

Every medigap advertisement that I have seen emphasizes that Medicare doesn't cover the catastrophic hospital bills. Well, who is going to pay for it? The ads go on to claim that their medigap insurance does cover all Medicare expenses. Now, we have a couple of charts down here that I would like, if some of the committee members can show as I describe some of the mumbo-jumbo that some of these insurance companies use in order to sell some of this coverage.

Mr. PEPPER. Could you put it up there?

Mr. HOROWITZ. If we could put up chart A. That is the large chart that you have in your hand. I don't know if you can see this clearly but I will explain it.

Chart A presents the frightening sum of $18,942 which Medicare will not pay for a patient who is hospitalized for 150 days. All right?

They claim their policy will pay $123 a day for every hospital day from 61 to 90 that Medicare doesn't pay. They fail to mention that the average hospital stay under Medicare—this is according to the 1985 figures—was 7.5 days. Very few people will need the sort of long-term hospital protection that this policy offers.

The type of catastrophic coverage most elderly people really want and need is long-term custodial care which, of course, we know Medicare doesn't give them. So few, if any of the Medicare policies even cover this.

Now let's look at the other chart, which is chart B, which is a little easier to read. Let's just study this for a moment after he puts it up.

This chart clearly shows that for hospitalization lasting 91 to 150 days, the policy will pay $246 for each day. The shocking truth is that the odds for a person 65 and older staying in the hospital 90 days or longer is 1 in 5,000. And the odds of a person in that age group staying 120 days or longer is 1 in 500,000. And yet, the ad looks like it represents total health care salvation for those people.

In truth, the older person could end up paying $35 a month premium for this policy and find him or herself collecting very little, if anything, in benefits.

Of course, some of these policies, for those of you who haven't read the policies, offer some tremendous benefits, like maternity benefits. A woman in Rhode Island told me that she bought a medigap policy that offered her maternity benefits, and she said she wished that she could be able to use those benefits at her age—she would love it. But those are some of the things that are written into these policies.

What they do not put in these policies is that they will not take care of the big and sometimes bankrupting bills, some of the bills that have been described by some of the witnesses on this panel, associated with nursing home care which costs between $20,000 and $50,000 a year. They will not pay for dental care or dentures, which is exceedingly expensive; they will not pay for home care except under very, very special circumstances; they will not pay for hearing aids or eye care or eyeglasses for routine doctor's visits, or for out-of-hospital prescription drugs. And I can go on and on and on in the exclusions.

These medigap policies, or medicrap policies, which I think very aptly, as I said, puts where they are, are misleading. They are intended to lull a perspective purchaser—like some of the folks that we have listened to—into believing that all of their medical bills will be covered regardless of whether or not Medicare pays. And while the charts and the sample policies are instructive, they can't tell you one thing my mail tells me. My mail tells me in the thousands and thousands, that there are still many insurance agents who fail to comply with the State laws in the United States and who lie, and who manipulate these senior citizens in order to make a sale.

Why is it that only in a court of law we are sworn to tell the whole truth? In a funny way, these ads are true, but, unfortunately, it is not the whole truth. As I have said, few, if any purchasers, of these medicrap policies will ever have catastrophic hospital bills.

The implementation of the perspective payment or DRG system makes that virtually impossible. The only people most of the Medigap policies protect are the insurance agents and also the insurance company executives, and the marketing people who devise and put out the plans on how to sell these policies.

The high premiums and the excessive commissions protect these people from well-deserved unemployment, because that is where I think they belong. I would love to see the Federal Government pay them something for their unemployment rather than for cheating the senior citizens of this country.

The purchasers of Medigap policies do not get the protection they need and the protection they believe that they are getting. When their loved ones contract, unfortunately, diseases like Alzheimer's disease, for example, or any other disabling condition, they will be saddled with catastrophic nursing home bills, which could bankrupt any family.

It is no wonder that these hucksters don't even mention the fact when they are selling these policies—they have nothing in their bag of tricks that tell people that they will even pay for something like Alzheimer's disease if you examine these policies closely.

Even worse, when it is too late and the senior citizens have been sold the worthless insurance, which some of the folks on this panel have talked about this morning, too often their complaints are not acted upon by Federal and State authorities. Too frequently, these senior citizens are treated like fools, or like wrinkled children, or even totally ignored when they complain. Or in some offices that sincerely desire to help, funding for personnel has been so sharply curtailed that there is no one really there to crack down on the charlatan who sold them the policy—and that is true of many offices of the Federal Government that I deal with.

Now, I know that there are some excellent State insurance commissioners and attorneys general, and I never fail to be impressed with the Postal Inspection Service's response to some of the frauds that are out there and some of the things that I bring to their attention. Nevertheless, these efforts are small comfort to the older Americans financially devastated by a loved one's bout with Alzheimer's disease, Parkinson's disease, cancer, or whatever. It can only be emotionally and financially devastating to learn that the insurance that such families counted on to aid them is not there in an emergency, but they are also then faced with the prospect of a bankruptcy.

Most of the people that I have encountered from the insurance industry through the years are responsible citizens, I believe, trying to do a good job of providing Americans with the protection that we need, and trying to sell it at a price that we can afford.

Why these same responsible people in these insurance companies that are catering to senior citizens haven't cracked down on the handful of companies who prey on the elderly and tarnish the reputation of the insurance industry is a major disappointment to me as I am sure it is to you, Claude, and all the folks who are sitting up there on that panel.

And why we can't throw those agents who lie and cheat in jail for violating a Federal law, which is a felony for them to do that, is also beyond me.

I don't know how many cases have been prosecuted against these people. In doing my research, I could not find one. Maybe some member on the panel knows of one.

Mr. Chairman, I feel that every State should establish minimum education, training, and moral standards for insurance agents to

abide by. They have to be licensed. Every agent should be bonded. States should make insurance agents fiduciaries, legally responsible for selling only insurance suited to the individual's needs and income. Those who fail in their responsibility should be liable, I think, for not single or double, but for treble damages, attorney's fees, and also very hefty fines on top of all that.

Finally, every State, I think, should do something constructive to answer the thousands of requests from senior citizens who ask for help and understanding and comparing these insurance policies. Yes, the Better Business Bureau will talk to them. Yes, the American Association of Retired Persons will talk to them. But there has to be more than that.

At a minimum, every insurance commissioner should have a plain English explanation of what every policy sold in that State should cover and what it doesn't cover. The exclusions should be spelled out in simple English that everyone can understand.

The loss ratio, which is very important for each company, for each of its policies, should be collected and made available to the person who is going to buy it so that they have some knowledge of at least what those companies are paying out in claims.

You know, it is painful to look around and see people who have worked the longest to make this country great, who have been through the wars, who have been through the Depression, who are responsible for all of us sitting in this room today, and to see these same people as prime victims cheated by unscrupulous insurance salesmen and sold every conceivable form of medical quackery product on the market and also insurance scams. I think probably the best way to eliminate the evils is to make Medicare into a program which really covers all forms of catastrophic health expenses. What Mr. Pepper is proposing in his bill; what Mr. Wyden says that he will support, I think that is where we have to go.

Surely, we can harness our ingenuity to design a program which provides the best possible health care that we can afford for our senior citizens because our senior citizens are really basically why we are all here.

Thank you.

[The charts follow:]

LENGTHY HOSPITAL STAYS PAID FOR BY MEDICARE

LENGTH OF STAY	% OF TOTAL CASES		ODDS FOR ALL 65 AND OLDER	
	1981	1984	1981	1984
60 DAYS OR MORE	3%	0.5%	1/250	1/1,428
90 DAYS OR MORE	0.7%	0.16%	1/1,000	1/5,000
120 DAYS OR MORE	0.02%	0.0017%	1/35,000	1/500,000

YOU PAY under Medicare Part A during each benefit period

- The Initial Hospital Deductible
- Extra cost of private room, unless medically necessary
- Cost of first 3 pints of blood
- Hospital Coinsurance for 61st through 90th day & 60 day Lifetime Reserve
- All hospital charges after all Medicare benefits run out
- Skilled Nursing Facility coinsurance for 21st through 100th day
- All Skilled Nursing Facility charges after the 100th day
- All charges in a Skilled Nursing Home not certified by Medicare
- All in-hospital Private Duty Nursing (R.N.) care charges

YOU PAY under Medicare Part B each year

- Medicare's calendar year deductible
- All Medicare coinsurance (the 20% Medicare does not pay) for medical and outpatient hospital expense amounts approved by Medicare
- All medical and outpatient hospital expense in excess of amounts approved by Medicare

YOUR MEDICARE provides these benefits during each benefit period

- The Initial Hospital Deductible 492.00
- Extra cost of private room, if not paid by Medicare ... No Limit
- Cost of first 3 pints of blood
- Hospital Coinsurance for 61st through 90th day & 60 day Lifetime Reserve ... No Limit 123.00 A DAY
- All hospital charges ... No Limit 246 A DAY
- Medicare's Skilled Nursing Facility coinsurance for 21st through 100th day 61.50 A DAY
- Medicare's daily coinsurance amount from the 101st through 365th day 61.50 A DAY
- The Medicare Skilled Nursing Facility coinsurance amount for the 21st through 100th day of confinement 61.50 A DAY
- Up to $30 per 8-hour shift of Private Duty Nursing (R.N.) care — limit of 2 shifts a day for 90 days

YOUR MEDICARE provides these benefits each year

- None of the calendar year deductible. (Maryland: ☐ The calendar year deductible.)
- All Medicare coinsurance (the 20% Medicare does not pay) for medical and outpatient hospital expense amounts approved by Medicare ... No Limit
- Subject to the charges not exceeding 150% of the amounts approved by Medicare, will pay (after $200 of such excess in the calendar year) 80% of excess ... No Limit

LIMITATIONS AND EXCLUSIONS

EFFECTIVE DATE OF COVERAGE

MAKE CHECK PAYABLE TO COMPANY

Received of _____

the sum of $ _____ for _____ month's premium with application for Policy Form _____. If for any reason policy is not issued, payment is to be refunded in full. Insurance is not effective until policy applied for has been issued.

Date _____ Authorized Signature _____

Keep This Page — Attach it to Your Policy

It highlights the benefits of your policy. It is not a contract. Your actual policy provisions (which may vary by state) will govern your benefits.

This card is the key to help pay what Medicare does NOT

[redacted]

YOUR NAME
YOUR CERTIFICATE NO.

[redacted]

[redacted]

Everyone 65 or over needs this card

[redacted] PAYS

- ★ 100% of your initial in-hospital deductible when you choose [redacted]
- ★ 100% of your in-hospital co-payments
- ★ 100% of your Medicare allowable expenses for one full year after Medicare stops
- ★ 100% of your co-payments for Medicare allowable doctor, medical and surgical expenses—in or out of the hospital

Here are your [redacted] cash benefits

MEDICARE Part A Hospital Bills	MEDICARE Does Not Pay	[redacted] (the premium plan) Pays	[redacted] (the economy plan) Pays
Day 1 through 60	First $492.00	First $492.00 NOT paid by Medicare	$0
Days 61 through 90	$123.00 EVERY Day	The $123.00 every day NOT paid by Medicare (Total: $3,690.00!)	The $123.00 every day NOT paid by Medicare (Total: $3,690.00!)
Days 91 through 150*	$246.00 EVERY Day	The $246.00 every day NOT paid by Medicare (Total: $14,760.00!)	The $246.00 every day NOT paid by Medicare (Total: $14,760.00!)
TOTAL at end of 150 days	$18,942.00!	The total $18,942.00 NOT paid by Medicare!	A total of $18,450.00 NOT paid by Medicare!
After 150 days	Medicare Stops Paying	100% of all Medicare allowable hospital bills for one full year after Medicare stops!	100% of all Medicare allowable hospital bills for one full year after Medicare stops!
Doctor, Medical, Surgical Bills (Medicare Part B)	20% of your Medicare allowable expenses—after you pay the first $75 each year	The 20% of your Medicare allowable expenses NOT paid by Medicare—up to $100,000 a year—after you pay the first $200 of such charges. (This includes Medicare's $75 expense requirement.)**	The 20% of your Medicare allowable expenses NOT paid by Medicare—up to $100,000 a year—after you pay the first $200 of such charges. (This includes Medicare's $75 expense requirement.)**
OPTION Skilled Nursing Facility (Medicare Part A) Day 1-20***	NOTHING UNPAID		
Day 21-100	$61.50 EVERY Day	The $61.50 every day NOT paid by Medicare (Total: $4,920.00!)	The $61.50 every day NOT paid by Medicare (Total: $4,920.00!)

*After 60 days of Hospitalization: Medicare give you a one time lifetime reserve of 60 additional days of protection (Days 91-150). However, once this lifetime reserve of [redacted] is exhausted, your [redacted] protection will begin paying 100% of your Medicare allowable bills the very day Medicare ends. And you'll have a lifetime benefit of a full 365 additional days (one year) of protection with [redacted]

**You pay any medical expenses not allowed by Medicare.

***Medicare pays 100% of all reasonable costs the first 20 days of Posthospital Skilled Nursing Care in a facility approved by Medicare. You must have been hospitalized for at least 3 days and enter the facility within 30 days after hospital discharge.

Exclusions: Prior health conditions (those for which you received medical advice or treatment within the last six months) are not covered for the first six months . . . loss due to act of war . . . for care in a skilled nursing facility (if option is not selected) . . . limited benefits for mental disorders . . . or for services, facilities, and unreasonable expenses not covered by Medicare . . . You may have only one [redacted] Medicare Supplement Insurance Plan.

- [redacted] benefits are paid direct to you or to the doctor or hospital.
- [redacted] policy can never be cancelled individually. As long as you pay your premiums and continue your Medicare coverages [redacted] master policy is not terminated, your protection cannot be [redacted]. Regardless of how much or how often you collect.
- [redacted] meets or exceeds standards for quality health insurance [redacted] (Public Law 96-265).
- Your rate can increase only if rates increase for everyone in your class covered by Master Policy (NHC-1380-1083) . . . or if your benefits are raised to match any changes in Medicare. You'll never be singled out for a rate increase, regardless of how much or how often you collect.
- Underwritten by [redacted] the insurance company nearly 2 million Americans depend on.

[redacted]

Any Questions? Call Toll-Free

[redacted]

Not affiliated with or endorsed by any Government or Medicare program.

Protection you can count on...

We'll pay for the kind of care you'll need:

- Skilled Nursing Home Care
- Intermediate Nursing Home Care
- Custodial Nursing Home Care
- In HMO Nursing Homes
- In Medicare Approved Nursing Homes
- In Non-Medicare Approved Nursing Homes

Nursing home care benefits

We'll pay the full daily benefit amount according to the plan selected by you, for each covered confinement due to an illness or injury

in any **Rec**ognized Nursing Home

When your doctor orders care in a Nursing Home for you, your stay can be a covered confinement if:

- You enter the Nursing Home within 30 days after a hospital stay of 3 or more days in a row, and
- Your stay is for the same or related illness or injury for which you were in the hospital

Home convalescent care benefits

When you leave the Nursing Home, we'll pay 50% of the selected daily Nursing Home benefit amount for as long as 180 days if you need

a program of medically necessary care

- ✓At your home
- ✓At someone else's home
- ✓At a retirement home
- ✓At a home for the aged

We'll pay these benefits for up to 180 days per covered confinement if:

- Your doctor orders the care as medically necessary, and
- The program begins as soon as you leave the Nursing Home, and
- Nursing Home Care lasted for some period 90 or more days in a row

Renewability feature

To keep your coverage in force, just keep paying the premiums on time.

We can't refuse to renew your coverage during your lifetime, unless we refuse to renew all CR-720 policies in the state where you live, too.

We can't make any changes to your policy because of a change in your health. If you pay the premiums on time.

Waiver of premium feature

After we've paid benefits for 90 days in a row, you won't need to pay premiums while benefits continue to be paid for consecutive days of your

Nursing Home or Home Convalescent Care.

You won't really want to have to worry about premium payments when you've been confined that long, will you?

The right time to think about insurance is now, not then!

Ambulance service benefits

We'll pay $

is covered by CR-5 policy.

Restoration of benefits feature

new benefits can start again

Pays cash benefits in addition to what Medicare, Blue Cross, Group Insurance and any other insurance from any other insurance company pays.

Pays cash benefits even if you've signed up for an HMO, PPO, CMP or other Pre Paid Health Plan.

Thirty (30) day free look...

If you aren't completely satisfied with the policy, you may return it within 30 days for a full refund.

Design a plan for your peace of mind. A plan suiting your needs and your budget.

Daily benefit amount options

You can now select the amount of Daily Cash Benefits that will be paid for stays in the Nursing Home.

The options are:

$20 Per Day
$30 Per Day
$40 Per Day
$50 Per Day
$60 Per Day
$70 Per Day
$80 Per Day
$90 Per Day
$100 Per Day

For your information the current MediCare Skilled Nursing Facility Copayment amount is $ per day.

Benefit period options

You can also select the maximum length of time for which your policy could pay Nursing Home benefits for any one injury or sickness.

The options are:

1 year
3 years
5 years

Elimination period options

You can also select when benefits can begin to be paid during your stay in the Nursing Home.

When the Elimination Period ends, the selected Benefit Period begins.

How long can you afford to wait?

The options are:

0 Days
20 Days
100 Days

The longer the Elimination Period, the lower your premiums.

For Your Selected Plan, the Premium will be $ each

No matter which plan you've selected, benefits will never be reduced because of your age or the kind of Nursing Home Care you receive.

Mr. PEPPER. Thank you very much.

How fortunate the elderly people are, in fact, like all the people are, to have a sentry like you on the watch towers. I wish there were many more of you. Keep up your good work.

Mr. HOROWITZ. Thank you.

Mr. PEPPER. Another able member of our committee has come in now. Would you like to make a statement, Mr. Vento?

Mr. VENTO. Thank you, Mr. Chairman. I will reserve that opportunity until all the witnesses have finished.

Mr. PEPPER. Thank you very much.

Now, the next will be Mrs. Lillian Simmons. She is the Subcommittee Senior Citizen Investigator from Arlington, VA and the lady that made the excellent statement on CBS with me this morning. Mrs. Simmons, we would be pleased to hear you.

STATEMENT OF LILLIAN SIMMONS

Mrs. SIMMONS. Mr. Chairman and members of the subcommittee, my name is Lillian Simmons. I am 68 years old. I am a widow recently relocated to Arlington, VA to be close to my daughter and her family.

Early in 1986, I sought and obtained volunteer employment with the Subcommittee on Health and Long-Term Care. I was always active with senior citizens during my working years and wanted to continue making my contribution by working with Congressman Claude Pepper. In May, I was asked if I would serve as a senior citizen investigator for the subcommittee during its inquiry into the sale of insurance to supplement Medicare. I was enthusiastic to help out. I had Medicare and also a policy to supplement Medicare with the American Association of Retired Persons. An insurance expert told me I was adequately covered, given my financial means.

To ascertain whether insurance agents would employ abusive sales tactics, I was asked to interview at least a dozen agents between the months of May and June of 1986. I agreed. I talked with a dozen agents from the District of Columbia, Virginia, and Maryland.

Literally every agent I interviewed, except one, tried to replace my existing policy. I later learned that this practice is known as "twisting"—an agent encourages the client to cancel perfectly good coverage to sell a new policy which results in additional commission fees and imposes a new waiting period for preexisting conditions, which would have left me uninsured for a period of time.

Most of the agents tried to overload me with additional insurance which duplicated coverage I already had, at a cost that exceeded—in one instance, by 400 percent—the premium I already pay. One agent simply dismissed my current insurance as "non-insurance"—as "worthless certificates." Another suggested that life insurance was a better answer to explore in coping with health security. Several agents resorted to scare tactics and horror stories to erase any doubts I might have about purchasing their policies. One agent said, "I just sold this policy to an elderly couple and they would have lost their trailer without it. You don't want that to happen to you, do you?" I don't own a trailer.

The double talk I encountered would have left the average uninformed consumer's head spinning. At the beginning of one interview, an agent apologized for his lack of knowledge regarding his company's Medicare supplement insurance plans. He said, "We seldom get calls for this kind of insurance, so pardon me if I take a little time in explaining its benefit package." Toward the close of his presentation, he once again apologized to me for not bringing a brochure describing his Medicare policy, adding, "I must have just run out of this brochure. It is such a popular policy. In fact, I will probably get two more calls for it tonight."

In the District of Columbia, two different agents from the same insurance company presented their identical policies to me. The one agent told me that I should keep my policy and buy his, too. The other agent told me I should buy his policy and drop mine. In the former instance, I would have been overloaded because I would be paying for two policies where only one would pay if I needed to use them. In the latter instance, I would be asked to pay a higher premium on a policy which would have duplicated my existing insurance and also I would be left uninsured for a period of time due to my preexisting condition of high blood pressure.

In all, I saw one dozen agents and only one told me that he had nothing to offer me—that I was adequately insured, given my financial means. He told me that I could not purchase nursing home insurance—nothing good was available.

All I can say is that, if in medical circles a second opinion is helpful, that principle does not apply to health insurance in supplementation of Medicare. I got 12 different opinions from 12 different agents. I was only going through the motions of looking for a policy, but a great many seniors are actually victimized each year by unscrupulous agents. Hopefully, my experience will lead to needed reforms.

Mr. PEPPER. Thank you very much, Mrs. Simmons.

Right about the time of our 1978 investigation into this subject, we arranged, with the concurrence of one of the networks, to have TV coverage of one of these agents trying to sell one of these insurance policies to an elderly lady. She was working with our subcommittee. He thought she was a bona fide applicant for a policy. So the camera was there so that we could get the sight and sound of what that agent said to that lady, to whom he was trying to sell one of these policies.

What reminded me was what Mrs. Simmons said—I wish we could have had a videotape record of every one of those agents trying to sell those policies and what he said to this lady. The American public would have had an opportunity to see the tactics that they employ.

So then he sued us. He sued our committee. It was in court for quite a while. The case was just dismissed and the judge found we were entirely justified in making a record of what this man said and did, how he did it in trying to sell these specious policies to an elderly lady who allowed herself to be his customer, he thought. So we are so glad to have you.

It is a tragic commentary on the professional ethics of these agents. We found out that some of the companies deliberately train these agents to make that kind of a sales pitch. So it isn't just the

avarice of the agent in every case. Sometimes it is brought about by the action of the insurance company.

Thank you very much for bringing us this vivid story.

Mr. PEPPER. The last member of this excellent panel is Mr. Robert Hunter, President of the National Insurance Consumers Organization of Alexandria, VA.

Mr. Hunter, we will be pleased to hear from you.

STATEMENT OF J. ROBERT HUNTER

Mr. HUNTER. Thank you, Mr. Chairman. I appreciate the opportunity to be with you again, because as you heard this morning, the same sort of crisis you documented 8 years ago still exists. I do appreciate your leadership on this issue—your continued leadership.

The crisis goes on because the Federal policy toward health insurance remains one of not giving full health insurance to Americans—the only industrialized nation in the world that doesn't—and the timidity of Congress and the administration in seeking a real solution, either by closing the gaps that are left in the coverage that we have, or by directly providing the insurance, or by firmly regulating the insurance that is provided. One of those three approaches has to be the answer.

It is our Nation's health insurance policies that leaves these elderly people vulnerable, like we heard this morning, to these kinds of sharp practices.

Every day, elderly people are buying too much health insurance, so-called medigap health insurance, and still, when a major illness occurs and people end up in a nursing home or otherwise, they go to their financial ruin—only their financial ruin is a little earlier because they have several thousand dollars of medigap insurance purchases to lower their net worth.

Out of love and fear, the elders act. They love their children, and they fear that they would be a burden on them if something happened. So they are routinely victimized by sharp dealing blue suede shoe health insurance salesmen.

The National Insurance Consumers Organization gets more complaints from elderly people who are confused and afraid, than on any other thing except auto insurance claims. It is the second leading complaint that we get.

When I appeared with Phil Donahue a few years ago and mentioned this subject, I got 3,000 letters on it—just from one little mention on a television show. So there is a tremendous concern in the public about this.

Now, the patchwork quilt of Medicare coverage is one of the key problems. People can't understand what they won't be covered for. Congress could fix that by clarifying the coverage or by offering its own gap filler policy to cover it. But Congress so far has chosen to leave it to the private sector under State regulation to fill the gaps, and that is why we are here today.

For years, we have known that the problems have existed but have refused to deal with it head-on by fixing the gaps, or offering the gap coverage, or regulating the gap coverage because of the fear of the special interest clout of the insurance industry and a

lust for reelection that the insurance industry PAC dollars can help assure.

When I came to the Federal Insurance Administration as Chief Actuary in 1971, one of the first things the Nixon administration put me to work on was this problem. When I became Federal Insurance Administrator under President Ford, we worked on this problem. We have been working on this problem for at least 15 years since I have been here--and it wasn't new when I got here.

Now, your current bill, Mr. Chairman, H.R. 4287, would enable citizens to purchase medigap insurance directly through the Medicare Administration, and the National Insurance Consumer Organizations is happy today to endorse that approach.

Mr. Chairman, your bold leadership in 1978 is to be commended, when you first exposed the practices that we are again discussing today. Your proposal for a Federal seal of approval for policies would have been a good step, however——

Mr. PEPPER. May I interrupt you just one minute?

Mr. HUNTER. Yes.

Mr. PEPPER. Mr. Hunter is referring to a provision that we got in the 1980 law, which gave the insurance company making these kinds of sales an opportunity to have public governmental approval of not only the merit of that policy but the kind of salesmanship that they employ in the sale of that policy.

In other words, the 1980 law permitted any insurance company which wanted to get a government certificate of approval—something like the Good Housekeeping seal of approval on a product—to file with the Government the policies that they were selling and the policies of salesmanship that they employ. And if the Government found those to be commendable or desirable, then the Government could give that company a certificate. The company could then advertise to the public that their policy and their method of sale was approved by the Government of the United States.

We haven't had one case—isn't that correct—we haven't had one case where an insurance company has chosen to get that certificate of approval from the Government of this country.

Go ahead, Mr. Hunter.

Mr. HUNTER. The reason you don't have one is that there has never been a seal developed—I have yet to see it. It is like the rabbit in Harvey—it is invisible. So, no one can get it because no one has produced it. The administration has not, to my knowledge, developed the seal; in part, because they have read the legislation to say that if the State government takes some action, it ousts the Federal Government, including the seal—which is not the way I read the legislation, but that is the way they have interpreted it.

As a result, we still have at least $2 to $3 billion of waste in this Nation today. When you documented it 8 years ago it was only 1 billion. We have at least doubled, perhaps tripled, the waste and abuse. That ignores what I consider the continuing ripoff of cancer insurance, which also falls heavily on the elderly. I am just looking at the standard medigap policies, not including the cancer insurance, which is also oversold and overpriced.

Now, a lot of this abuse, of course, ends up by being borne by the elderly by them being financially wiped out. Some of it is borne by the Federal Government indirectly through Medicaid payments

that the Federal Government has to pay that they wouldn't have to pay if these policies were properly controlled. And we end up with higher costs due to hospital stays that are forced because they don't cover things like nursing homes.

So we have a system that encourages the wrong level of care and in fact encourages wasted Federal dollars as well as individual dollars and ruined lives.

Now, why does this go on? In part, because of the timidity of Congress, as I said, because Congress has not addressed head-on these issues.

Now, the other problem has been the lack of adequate Federal response even where Federal response is allowed. The lack of the seal of approval is an example of that. But also, where in the world is the Federal study of State regulation of insurance that was due in 1982, as I read the legislation? It is now 4 years late. If the Federal Government is that weak, maybe it wouldn't be much better than the State government in regulating insurance after all.

But in 1979, the General Accounting Office issued a report called "Issues and Needed Improvements in State Regulation of the Insurance Business" and said that the States had serious shortcomings, no systematic procedures to determine if consumers are being treated properly.

The quality of State regulation is just very low. I think it has been made most manifest in the current liability insurance crisis, which has been caused by a vicious economic cycle that the State regulators have failed to control.

Now, there was a Senator in 1945 who stood up and said, when the McCarran-Ferguson Act passed and gave the States the authority to control insurance, that we had to watch out. And I again congratulate you, then Senator Pepper, for your foresight.

You were the only one who stood up on the floor of the U.S. Senate and warned that the kind of practices that we are seeing today might happen, because the Federal Government was going to allow this ongoing exclusion from antitrust law enforcement.

Mr. PEPPER. Yes, I remember that is when the insurance companies were trying to escape from the antitrust laws.

Mr. HUNTER. Successfully.

Now, the States lack the resources and the will to accomplish the task of what the 1980 amendments—the so-called Baucus amendment—delegated to them, including the seal of approval and the like.

The GAO report noted that the States were unable to show an arm's length relationship between the regulated and the regulators. That is one of the problems.

But the other problem is, as I talk to State regulators is, since they took on this additional responsibility of regulating the medigap policies, their staffs have in fact been cut, that they just don't have the people to go ahead in there and regulate it. So that is one of the key problems. And I think that is one of the reasons you haven't seen the report, because I think it is going to be clear when the report is ultimately produced, that the States don't have the staffs to handle the problem.

Now, a few States have done some good things. Pennsylvania has done some pretty good control on the government look type policies

and have outlawed a few of those. Florida and Arizona have developed some fairly good information on the abuses and have gone after them fairly vigorously. But only a handful of States have really done anything like the job necessary to control this situation. That is why we have people like you have heard earlier this morning.

Mr. PEPPER. You know, of course, Mr. Hunter, that the Federal Government has not complied with the 1980 law that would give a report to Congress?

Mr. HUNTER. That is correct. That was due 4 years ago, I think.

It is a shock to me because the States have failed. Only 26 States in the United States have actuaries on the staff, for example. How are you going to know whether you are actually getting a 60-percent loss ratio if you don't have an actuary? Half the States—more than half the States—don't have the horses. The other half don't have the will because the Governor or the insurance commissioner, if he or she is elected, oftentimes is dependent on the insurance company PACs for reelection campaign money.

I have been pressing in the National Association of Insurance Commissioners for several years for loss ratio disclosure, not only in medigap, but generally. They have adamantly refused to consider it because the insurance companies don't want to do it.

Now, I conclude that the Federal Government has allowed a major industry to grow up around a flawed and incomplete Medicare system which it created, an industry that preys on the elderly and kind of lies in wait for those of us who haven't quite gotten there yet. But this national scandal persists despite continuous documentation of its cruel impact. While the States have contributed to the failure, the primary cause is here in Washington. The era of outrage continues. Congress must get off of the timid road and do something about it, Mr. Chairman.

[The prepared statement of Mr. Hunter follows:]

PREPARED STATEMENT OF J. ROBERT HUNTER, PRESIDENT, NATIONAL INSURANCE CONSUMER ORGANIZATION, ALEXANDRIA, VA.

Mr. Chairman and Members of the Subcommittee, I appreciate your invitation to address one of the most serious, ongoing dilemmas facing America's mounting mature population.

The dilemma exists and persists because of federal policy toward health insurance (we remain the only industrialized nation that leaves our elders significantly to their own devices) and the timidity of Congress and the Administration in seeking a real solution either by closing the gaps they create in the coverage or directly providing or regulating the gap coverage.

Every day elders fall -- through the ever-expanding inadequacies of Medicare coverage -- to their financial ruin. Every day other elders -- seeing the fate of their peers -- are buying private insurance policies, sometimes many of them, that are inadequate to fill the gaps, that are too expensive, that overlap coverage, and that, in short, rip-off the purchaser. Out of love and fear, love for their children and fear that they might be a financial burden on them, elders are routinely victimized by the sharp dealing, blue-suede-shoe health insurance agents prompted by excessive commissions to sell the wrong policies.

COVERAGE SHORTFALLS

Congress has created this Frankenstein-Medigap-Monster by creating a patch-work quilt of Medicare coverage which leaves all sorts of confusing holes in that coverage at the top, sides and bottom (deductible) of the insurance system that government provides. Congress could fix that, if it had the will, by making the insurance it provides more comprehensive or by offering its own gap filler policy, even at actuarially appropriate rates. Congress could also solve the problem by simplifying coverage (e.g., we will cover all over X percent of your adjusted income, then the gap would be clear and easier to fill). But Congress chooses to leave it to the private sector, under state regulation, to fill the gaps.

TIMIDITY

Congress has known for years that these problems exist, but has refused to deal with it head-on, either by fixing the gaps, offering the gap coverage, or regulating the gap coverage. Why? Fear of the special interest clout of the insurance industry and a lust for re-election dollars that the industry generates.

The exception to timidity in this area has been yourself, Mr. Chairman. Your current bill, HR-4287, would enable citizens to purchase Medigap insurance directly through the Medicare Administration, so no one would have to be concerned about gaps or overlaps. It is an approach NICO is happy to endorse today although, ultimately, we feel that tha nation should move in the direction of a comprehensive national health insurance program for all Americans.

Mr. Chairman, you earlier showed bold leadership when, in 1978, you undertook your first in-depth analysis of the Medigap-insurance mess. Your report then documented fear tactics, overloading, overcharging and a general rip-off of the elders of this nation to the tune of an estimated $1 billion. You were first to propose a federal seal of approval for such policies, to make overselling a crime, to make policies that looked like official government documents a crime and other reforms.

Insurers held off your reforms by fierce lobbying (one often wonders why the insurers who do not engage in such callous practices join in helping perpetrators continue to get away with such acts which will inevitably give a black eye to all insurance companies). So today, the rip-off continues albeit for even more than $1 billion. We estimate that the money wasted must be at least $2-3 billion today.

What emerged occurred because you did document a national scandal so great that something had to happen even given an intense lobbying effort. What emerged became known as the "Baucus Amendment" (named after Senator Baucus of Montana). This bill allowed for state programs to oust the federal certification you wanted, and was a program of voluntary certification. It did, happily, outlaw the oversell and the "official government look" problems, but they persist even given this legislation.

The approach was more timid than needed, knuckling under to insurer lobbying. The approach has failed.

LACK OF ADEQUATE FEDERAL RESPONSE

Where is the federal seal of approval? It is like the rabbit in Harvey -- invisible. The combination of states ousting federal certification and the Reagan Administration's interpretation of the Baucus Amendment that the federal seal can't go on to a state certified policy (an interpretation with which I disagree), has eliminated the only sure way our elders had to see if a policy had proper coverage. The lack of certainty has continued the confusion and the financial consequences of the confusion that you documented in 1978.

With one exception (the problems insureds have with getting a fair settlement in auto insurance claims) the largest number of complaints NICO receives is from the elderly regarding the gaps in Medicare and their despair at understanding what coverages they need, how much to pay, which insurers are reliable and fear of long-term, catastrophic illness. Many letters came from children of people who overbought coverage or bought worthless policies (getting the elders and their children to work together on a project is wonderful, but there must be a less outrageous way to accomplish it).

I also wonder where is the federal study of State Regulation of Insurance that the U.S. Department of Health and Human Services was supposed to have produced by now? When will the federal government face up to its responsibility to fix the mess it has caused?

THE STATE ROLE

In 1979, GAO issued a report, Issues and Needed Improvements in State Regulation of the Insurance Business. It concluded that state regulation was in need of significant upgrading to accomplish consumer protection since states have such "serious short-comings" as not having "systematic procedures to determine if consumers are being treated properly."

Today, the quality of state regulation has become manifest in the infamous liability crisis, brought about by states failing to regulate the insurance economic cycle (see chart). The cycle itself is proof of a serious failure since

it shows that rates swing from wildly excessive (as in the late 70's and again at present) to inadequate (as in 1975 and 1984), each producing a "crisis" insurers blamed on the legal system. Yet, every state has a law that requires that such rates be neither excessive nor inadequate. Perhaps it is because, today, 26 states do not even have one actuary on staff!

The states lack the resources and the will to accomplish the task the Baucus Amendment delegated to them. They are, as the GAO report noted, unable to show "an arms-length relationship between the regulated and the regulators." Even many state regulators I have talked to have admitted to their failure to get any staff to police Medigap, in fact they have seen staff outs after taking on the Baucus Amendment responsibilities.

The problem with the Baucus Amendment is, quite simply, that it did nothing to stop the sharp sales practices over the kitchen table -- the fear tactics, the lies, the hard sells. Nor can any bill. Only closing the gaps or direct provisions of insurance or direct regulation of the provisions of insurance will work, I fear.

TV SALES

Another problem is that the TV approaches to selling these coverages using "trusted" personalities, overselling and often misleading Americans into inappropriate insurance decisions. FTC has shown no interest in controlling false advertising vis-a-vis insurance (they even refused a NICO request to investigate false claims in advertising a book about insurance, claiming that the euphemistically labeled "FTC Improvements Act" which forbids the FTC study of insurance ousted their authority to do so).

Only a few states, Pennsylvania for example, have done some good work to outlaw "governmental look" policies and abusive sales pitches, but abuses persist. Florida and Arizona also deserve praise. But that the handful of states that have tried stick out like sore thumbs is further evidence of the failure of the states to stop the abusive practices.

CONCLUSION

The federal government has allowed a major industry to grow up around the flawed and incomplete Medicare system it created -- an industry that preys on our elders and that lies in wait for those of us not yet quite of Medicare age. The national scandal persists despite continuous documentation of its cruel impact.

While the states have contributed to the failure, the primary fault lies right here in Washington. The era of outrage continues. Will Congress continue on the timid road or will it deal with this problem head-on and solve it? Your leadership is vital, Mr. Chairman and Members of the Subcommittee. The nation appreciates the work you and your staff have started but urgently await the completion of your task.

Thank you, Mr. Chairman. I would be happy to respond to your questions at the appropriate time.

Mr. PEPPER. Thank you very much, Mr. Hunter.

Now, then, we will have questions from the panel. I am sure the panel will keep the questions as brief as they can because we have a good many other excellent witnesses to hear.

Mr. Wyden.

Mr. WYDEN. Mr. Chairman, I have just one question and I want to note that you mentioned the administration not complying with the requirements of the 1980 law. But it is my understanding that your 1980 law also prohibits the look-alike kind of policy, and it is clear that that is not being enforced as well. Again and again, around this country, you see a situation where the letter from the company is mailed from Baltimore, it has an identical format as a Medicare claims letter, and the insurance company is saying the senior citizen must buy this supplement. It is clear that these private look-alikes are tricking a lot of seniors into thinking that that is coming from the Federal Government.

I just note that that is another part of your 1980 legislation that is not being complied with and it is a clear requirement of the statute.

The question that I had for the panel deals with the TV pitchmen. Mr. Horowitz, you said it so very well. We have got a situation where the star is right there on television, always in a comfortable kind of chair. It is just so cozy and nice. And the star leans back in a kind of sweater that you wear around the house and then the well-know actor says, I have got a guarantee for you. No matter what, no ifs, ands and buts, it is a guarantee. Just make one toll free call and you are secure for life. That is basically the way it works.

We know that there is a tremendous gap between what the pitchman—a well-known star—says and what the policy actually does.

What I would like is to ask the panel is what we could do that would be line with the first amendment. We don't want to do things to violate the first amendment. At the same time, we don't want false information coming out.

Do you think, for example, that it would be a good idea for the committee, under Chairman Pepper, to write a letter to all the stars and maybe the association of movie actors, and say, this is an area where we found tremendous abuse and we simply urge you, in the strongest possible way, to be much more careful about what you go on TV pitching?

Do you think something like that would be a useful solution?

Mr. HOROWITZ. I personally think that the people who are pitching these policies—the Danny Thomases and the Lorne Greenes—mean well.

I also think that they might not read these policies. You know, the Federal Trade Commission says that if you endorse a product or whatever, you have to use it. And if you listen to these commercials clearly, they say that, "I even have this insurance." I think that these people don't read the policies. They are approached by the insurance companies who give them a line and say, listen, by presenting this policy to the public, you are really going to be helping a lot of senior citizens. I think, really, basically, say, maybe I am doing something and, of course—they are being paid a fee for doing the commercials—that they are doing some good by doing

this. But I don't think if we had Danny Thomas and Lorne Greene at this hearing today, and we asked them to spout out the exclusions on the policy that they are selling, or what was covered, or what wasn't covered, I would be willing to bet that they wouldn't know, because they haven't read the policies.

I think your idea, Mr. Wyden, is an excellent idea, and that is to make the Guilds—AFTRA, the American Federation of Television and Radio Artists, as well as SAG, the Screen Actors Guild—aware of the fact that these policies are really very harmful to seniors, and that their members be aware that if they endorse a policy like that, they are endorsing a policy which could have exclusions that could be harmful to the people who are buying the policy in terms of their economic well-being. I think that is an excellent idea.

But I don't think any of these people are really breaking the law. I just think they are misinformed about what they are doing. The fact that we are holding a hearing like this today and mentioning their names will perhaps send them a message, and many other people who are in this senior category who are doing these commercials.

Mr. HUNTER. If I could just comment also. I have yet to see—I have studied a lot of these because I always get fearful when someone says here is a guaranteed policy that does everything and we can't refuse you. I will hasten to say to every American, that if it sounds too good to be true, it is. I have yet to see one of these policies that I rate a good policy.

So, people who buy from TV and mail order have to be very cautious.

Now, one key thing I would look into if I was the committee is the rather infamous FTC Improvements Act of 1980–81, where FTC was forbidden by law from even studying insurance. There was what I consider deceptive advertising on a book about insurance, and I appealed to the FTC to look at it. They said we can't look at insurance. I said, this isn't insurance, this is a book about insurance. They still wouldn't touch it. They said that has to be left to the States.

So if there is even fraud during advertisement, which normally the FTC would involve itself in, I think the FTC Improvements Act—how's that for a euphemism—may in fact keep them from looking at it.

Mr. HOROWITZ. There is one other point on this, which I think is a very key point. The local television stations, and the cable stations, and the network stations, that carry these commercials—they have to have ascertainment filed with the station according to substantiation of the Federal Trade Commission that says actually what these policies contain. And if you are making any kind of a claim, that claim has to be substantiated.

I think through groups like the National Association of Broadcasters and other industry groups for radio, the National Radio Advertising Bureau, that they be made aware of what is being said at this hearing today, and that they may send out some material to their stations to caution them about the fact that these policies make a lot of promises that are not included in the coverage and that a lot of senior citizens are getting ripped off by it.

I think to involve the professional groups in that is also a very positive step.

Mr. WYDEN. Gentlemen, I have no other questions. But I sit on another committee, the Energy and Commerce Committee, which has jurisdiction over telecommunications issues and the broadcast questions. I am very definitely going to work with Senator Pepper and my other committee to see if we can get the networks and the TV stations to change their practices in this area, because I think this is one of the key kinds of problems.

I share your view about stars, the kind of decent people that you are mentioning. It is hard to see them making deliberately misleading kind of statements. But clearly, we have got to turn this situation around. Although I share your view that most of the stars don't know what is in the policies, the first amendment shouldn't be used as a vehicle for things that are so outrageous and preposterous, and maybe in some instances, maybe even deliberately misleading. We have got to take some steps immediately to deal with this.

Mr. HOROWITZ. One other thing, Mr. Wyden, and members of the committee, I think it is also important, and I think this is key from the testimony that we heard from some of the people who actually were deluded into thinking they were having coverage that they didn't, is to have some sort of movement through the senior citizens organizations and the American Association of Retired Persons try to do it, is to get the people who are going to buy these policies to read these policies thoroughly. And if they don't understand the policies, have them call their local insurance person whom they have been dealing with, or a local chapter of the Gray Panthers, or a local chapter of the Better Business Bureau—as I alluded to in my remarks—who can explain it to them, so that they will know what it is before they sign the bottom line and buy it, and not just rip a coupon out of a Sunday supplement and buy the policy because it looks good on paper. I think that is also key.

I think what has happened for our seniors is that they have not gone through an educational system that has taught them to be aware and as informed as many of us are. And what we have to do is work more closely with the professional groups that they know so that they have some place that they could pick up the phone or walk into some of these senior citizens community centers and have someone there who can answer their questions before they buy these policies.

That is key, too, because what I heard here was testimony from people who had not read the policies until after the fact. I find a lot of America doesn't read that fine print unless there is a problem. I think that that is something that can be dealt with right now through senior citizen groups.

Mr. HUNTER. One just very short and final point, if I could.

Mr. PEPPER. Excuse me.

Mr. Horowitz, you will understand that I ask it in the spirit of friendship. I have not read my policies. Have you read yours?

Mr. HOROWITZ. Absolutely. I don't have any Medicare insurance.

Mr. PEPPER. I don't mean Medicare policies but your general insurance policies.

Mr. HOROWITZ. Yes; I read all my policies and I want to tell you that I read them before I buy them, Claude. I have a map with the insurance program to know what I want.

Mr. PEPPER. You are the exception, and I commend you. Good for you.

We are going to have, on the next panel, some States' attorneys general and insurance commissioners who will go into that aspect of it. I think your idea is good.

We ought to have a hearing, maybe your committee or this one, and have some of the TV people here. We could put the ad up there and then have the policy. We could say, do you think your ad is consistent with this policy and the like?

Mr. HUNTER. There is one other point, if I could. That is, that it is possible to work up a fairly simple disclosure document, either from each individual company or even a buyer's guide. I would recommend to you a quite excellent buyer's guide put out by Tennessee Legal Services, which makes it clear what policies cover and what they don't cover, and how much they cost, and compares them for people.

That kind of thing could be done if the States would take the initiative; but they haven't. Maybe that also would be helpful if some kind of Federal guide could be published.

Mr. HOROWITZ. It is getting the people to read them, too; that is the problem.

Mr. HUNTER. You have got to get them at the point of sale; that is the problem.

Mr. PEPPER. Thank you, Mr. Wyden. That was a very good question.

Mr. Wortley.

Mr. WORTLEY. Thank you, Mr. Chairman.

This is a very complex problem to be handled at the Federal level from this standpoint: That the courts have already ruled in at least three Supreme Court decisions that insurance is not the area of responsibility for the Federal Government, that it resides within the States' purview. This is one reason that we have a problem in addressing this aspect of it.

Mr. HUNTER. Sir?

Mr. WORTLEY. Yes, go ahead.

Mr. HUNTER. The McCarran-Ferguson Act delegates the authority to the State to regulate insurance, but only to the extent that a law that passed doesn't explicitly cover insurance, it is just up to Congress. If Congress had the will to pass a law that covers insurance, it could do anything it wants to on insurance. There is no limitation.

Mr. WORTLEY. I am very much in favor of having us get involved in insurance—in fact, we have to when we see what is going on here. But I appreciated Mr. Horowitz' observations that when a person is confronted with this insurance decision they should be calling a local senior citizens agency counseling service and asking for theirs, calling their Better Business Bureau, or perhaps their own personal insurance agent that would be willing to counsel them. That is a good idea.

Mr. HOROWITZ. But I also think the thing that is going to solve a lot of these abuses is the passage of bill H.R. 4287. I think Mr. Pep-

per's bill to provide catastrophic coverage is what we really need. Of course, the insurance industry, as you know, is going to be opposing it en masse here on the Hill. But I think that basically what we need is some more Federal involvement in this problem.

Mr. WORTLEY. But we have to act in the meantime to address this problem because it may be a little while before Senator Pepper's bill actually gets to the floor of the House for consideration.

We at the national level, of course, can address this somewhat to the U.S. Postal Service in the concern about fraud. We can focus some national leadership attention on it.

I would like to ask Mr. Hunter, in your testimony today we can see that the victim is left to his own resources to address this. Might you have a few basic steps that an individual could take if they feel that they have been a victim of some medigap abuse? Do you have any four or five rules that one can use?

Mr. HUNTER. First of all, the best advice is to get good expert help before you——

Mr. WORTLEY. Don't sign on the dotted line until you have been counseled.

Mr. HUNTER. Yes; unfortunately, our finding is that a lot of the elderly people that are buying these policies do so out of fear that they are going to be a burden on their children and don't talk to their children who might be in a position to help them, and end up with 27 policies. And then later the child finds out there are 27 policies, as we heard here earlier. Hopefully, the elderly people that hear this would be working with their children and others, advisers, trying to get good coverage.

But the problem is excellent coverage doesn't really exist at any price to cover these long-term needs—it is just beginning to emerge for the long-term care type of coverage. It is a real serious problem. So even with careful analysis you are probably going to have a gap in some of these long-term care areas.

Mr. HOROWITZ. Mr. Wortley, if I could just read this into the record, because maybe if we do this from an informative basis people will think about it. But I have some tips that I use on my TV show that I give to senior citizens.

Mr. WORTLEY. Wonderful. That is what we are looking for.

Mr. HOROWITZ. And what I say the first thing to do is to review your present insurance—what do you have. Don't waste your money buying more than you need to fill in the gaps in your current coverage. If you already have a good supplemental policy, you probably don't need another one—so you don't get into a situation where you are buying 15 or 20 policies covering the same thing.

Don't buy a policy on the salesperson's first visit, and that is really key. Get a copy or summary of the policy upfront. Take your time going over it with someone who knows your health needs and what you can afford. And that is key—afford to pay for the insurance.

Be sure you understand any restrictions or exemptions, or limitations, which would affect your medical benefits—which, again, would resolve some of the problems we have.

Once you have decided on a particular policy, fill out the application honestly and completely. That is very important, because some people don't do that and they get benefits they say they are enti-

tled to based on some fraudulent statement that is made on an application. You don't want to invalidate your policy by not telling the truth.

There are a lot of guides to medigap insurance that you can get free from your local Social Security office. They will tell you what Social Security pays and doesn't pay. There is also an excellent booklet that is available from the Better Business Bureau. Unfortunately, they charge a quarter for it, but it is called Tips on Medigap Insurance. I have read it and I think it is an excellent guide for people to use just as a basis to buying that insurance. That is what I would offer as my tips.

Mr. HUNTER. One final thought, too. If you are confused, since a court will hold a reasonable expectation of the insured is what was covered—if you are covered, either yourself, or your son or child should write a letter to the agent saying, this is what we think it covers. Write us a letter back and tell us if we are right. If they write back and say you are right, keep that letter with the policy, and if something happens later you have good evidence to help you.

But after the fact, if you have already bought the policy, or policies, and are in a hospital or a nursing home, more likely, and can't get the coverage, you are pretty much out of luck.

Mr. WORTLEY. I thank you very much. I yield back my time.

Mr. PEPPER. Thank you.

Mr. Vento?

Mr. VENTO. Thank you, Mr. Chairman. I am going to be brief. Let me say that I do agree with the idea that we ought to take strong national action in working with the States to deal with this problem. We haven't done that so far.

I arrived late and didn't hear all the testimony, but I think the environment in which this problem exists is one in which the promise of Medicare has become a broken promise. That is to say, there has been a serious erosion of Medicare benefits. It is unrealistic to expect that the private sector, through insurance or someone at the age of an elderly person or anyone else, is going to pick up medigap insurance on a monthly basis without paying some sort of an exorbitant price to cover the exposure that is not covered by Medicare. Obviously, in my review of this—and I have done a review of it, in fact held hearings back in my district on the issue—I found that very often the very coverage provided by Medicare is the same coverage that these policies offer. There is very good reason for this—the exposure, for prescription drugs, for nursing care, is such that you would have to charge a very, very large fee in order to have that type of coverage. It is just an actuarial fact.

So I think that while we can offer policies, nobody is going to be able to take the businesses out of the business of offering coverage for whatever still remains in terms of exposure.

I think the key here between this panel and the members is for us to focus on the critical points; to get the States and to get the National Government working together so that we eliminate the shenanigans that are going on. There are some. I am certain that these celebrities that choose to offer these policies are basically doing it in good faith, and that most companies do offer a good policy. It is good in the sense of what it is held out to do. But it

doesn't cover all of the gaps that exist, certainly, with Medicare, because the cost would probably be exorbitant.

Unfortunately, the only time you find out about the inadequacies of the medigap or supplemental policies is when the person experiences the problems, and then, of course, it is too late. As a society and as consumers we do take a rather casual attitude toward most insurance policies. We never get the policy until after we buy it. We buy it on the basis of brochures. We are trusting and relying on the industry. We hope that they would have the good sense to make the proper type of presentation. But that good-faith assumption does not always hold true.

But I do commend the panelists and those that are here, and hope that we can fashion a national policy that will address the fundamental problem. But the fundamental problem is that the promise of Medicare has been broken—it only covers 40 percent of the actual health care costs. In order to cover the remaining 60 percent, or a good part of it, the costs to us as a society, would be substantially more. I think that is the fundamental question that has to be addressed here. Within that 62 percent, that leaves a lot of exposure and a lot of room where people can begin to try and hold out promises, and a lot of promises actually that are false.

We are doing the best we can to fight the erosion of this and to do what we can to reinforce States. I know that Attorney General Skip Humphrey is here today, and that is one of the reasons that I wanted to be sure and be here, because he has been such a good advocate on these issues. But the State of Minnesota has, in fact, rated all of the medigap policies on a scale of plus one through three. So we do give that type of insight to the consumers in our State. But the focus is to get the consumers to look at those things and be in a position where they can operate on a basis of information rather than only trust, which hasn't worked.

Mr. PEPPER. Thank you.

Mr. HUNTER. Every American faces a catastrophic health insurance risk, even those in current group plans, because of the woefully inadequate conversion privileges. If I get very sick or hurt, my group will probably drop me because of the cost of that in their experience-rated premiums, and then I end up with a conversion privilege which often ends up taking away my catastrophic coverage. So, everyone, even those covered with group policies, have a genuine risk. So, we do have an actuarial base of the whole Nation and we can fund it, and it is doable, if we have the will.

Mr. PEPPER. Thank you very much.

Mr. HOROWITZ. Please don't forget that people are doing this, filling that gap, by misrepresentation and fraud also, in a lot of cases. I think you tend to say that people should read their policies but there are a lot of people out there who are taking advantages of the medigap and selling people policies fraudulently, misrepresenting, and making a lot of money off what these people think they are getting that they are not getting.

Mr. PEPPER. Thank you very much.

This has been an excellent panel and we are deeply grateful to all of you for the contribution you have made here this morning.

Thank you again.

Mr. PEPPER. We have another excellent panel coming along here now, and I will ask you to come up to the table if you will. Mr. Jack Swagerty, Assistant Chief Inspector, Criminal Division, Postal Inspection Service, U.S. Postal Service; the Honorable Hubert H. Humphrey III, attorney general, State of Minnesota, accompanied by Mr. Thomas Pursell, special assistant to the attorney general; the Honorable Peter Hiam, commissioner of insurance, Commonwealth of Massachusetts; the Honorable Earl R. Pomeroy, commissioner of insurance, North Dakota; and Mr. Donald Reilly, Leadership Council of Aging Organizations, Washington, DC.

First is Mr. Jack Swagerty. Mr. Swagerty, we are pleased to hear you and would like to have you proceed.

PANEL TWO—THE FEDERAL, STATE, AND LOCAL RESPONSE TO INSURANCE ABUSE: CONSISTING OF JACK E. SWAGERTY, ASSISTANT CHIEF INSPECTOR, CRIMINAL INVESTIGATION, U.S. POSTAL INSPECTION SERVICE, U.S. POSTAL SERVICE; HON. HUBERT H. HUMPHREY III, ATTORNEY GENERAL, STATE OF MINNESOTA, ACCOMPANIED BY THOMAS PURSELL, SPECIAL ASSISTANT TO THE ATTORNEY GENERAL; HON. EARL R. POMEROY, COMMISSIONER OF INSURANCE, STATE OF NORTH DAKOTA, HON. PETER HIAM, COMMISSIONER OF INSURANCE, COMMONWEALTH OF MASSACHUSETTS; AND DONALD F. REILLY, SENIOR VICE PRESIDENT, THE NATIONAL COUNCIL ON THE AGING, ON BEHALF OF THE LEADERSHIP COUNCIL OF AGING ORGANIZATION

STATEMENT OF JACK E. SWAGERTY

Mr. SWAGERTY. Thank you very much, Mr. Chairman.

Mr. PEPPER. I want to commend the excellent work of the Postal Service. They have been a tower of strength to our committee in this effort and we want to commend them.

Go right ahead, Mr. Swagerty.

Mr. SWAGERTY. Thank you very much, Mr. Chairman. It is indeed a pleasure to be back with you again.

I would like to begin this afternoon by presenting briefly an overview of the mission of the Postal Inspection Service and then I would like to talk specifically about our concern for the elderly as victims of fraud and some of the present programs we are using to educate them about frauds.

The Inspection Service is the investigative arm of the U.S. Postal Service. As such, we have investigative authority over all violations of Federal criminal law relating to the Postal Service. We are also responsible for the internal audit of postal operations and for the security of postal facilities and employees.

Postal crimes that we investigate fall into two broad categories: One is criminal acts against the Postal Service itself or its employees, such as armed robbery, burglary, or theft of mail. And the other is misuse of the postal system such as using the mails to defraud the public or the mailing of prohibited items such as bombs, and so on. Finally, we are responsible for investigating the violations of a number of civil statutes relating to the use of the mails, including the false representation statute.

Through our varied investigations, we have found that literally thousands of unsuspecting Americans are defrauded by those that use the U.S. mails to commit their crimes. Unfortunately, a number of those victimized are the elderly—and what better group to target? The swindlers and con artists are well aware that: senior citizens as a group are known to pay their bills, and pay them on time; senior citizens are less likely to protest, and to file formal complaints than the population as a whole; and senior citizens are more likely to use the mails for various purchases because of their reduced mobility and access to vehicles.

To give you an example of just how vulnerable the elderly are to fraudulent schemes, I would like to quickly tell you about a case we investigated and saw succesfully prosecuted last year. Over a 6-year period, beginning in 1978, a licensed insurance agent in New Jersey operated an insurance and investment scam against elderly clients. The agent solicited his clients' funds to purchase insurance policies and investment interests. However, rather than placing the policies into effect and transmitting the money to the respective insurance companies, he converted the funds to his own use. To further lull his clients into a false sense of security, he mailed them false and fictitious statements, policies and other documents to give the appearance that policies and annuities actually existed. Unfortunately, before this scam was exposed, the agent had defrauded 20 elderly people of about $800,000.

With this as a background, I would like to discuss another particularly harmful type of mail fraud aimed at the elderly, and the reason we are here today—the medigap insurance scam. Although we are not currently investigating any such cases, we know from past experience that there are unscrupulous insurance agents who prey on the fears of older Americans by selling, through the skillful use of half-truths and intimidation, worthless health policies. As you have already heard from the witnesses today, the victims are reminded of the high cost of medical care and how a serious illness could quickly wipe out their savings, thus transforming them overnight into a position of reliance on others. They are erroneously led to believe that by purchasing a medigap policy—a policy which supplements Medicare—they will avoid that fate. Some individuals are sold multiple policies which provide duplicate or unnecessary coverage. Furthermore, it is not uncommon, after paying thousands of dollars in premiums, as we heard today, for a victim's medigap claim to be either denied or perhaps partially paid at such a small fraction of the total amount, that it is hardly worth the effort to file a claim.

Seniors identified as "marks" or "soft touches" are often subjects of a technique used by greedy salespeople called "twisting." A salesperson's commission on the first year of a policy is normally very high—sometimes as much as 80 percent of the premium. Each year thereafter, the commission diminishes, so the unethical salesperson will "twist" the client from one company or policy to another in order to obtain the high first-year commissions. However, the negative effect of "twisting" isn't limited just to the monetary loss. Most medigap insurances require waiting periods before the coverage in policies takes effect. Thus, no immediate protection is provided the unsuspecting "insured" who, having not been in-

formed otherwise, believes he is covered as soon as he puts his signature on the policy.

Swindlers, acting out of greed, have found very fertile soil to cultivate in the senior citizen community. Their actions, limited only by the creativity of their devious minds, continue to be of concern to law enforcement officials, and pose a very serious threat to the financial security of the elderly.

Our agency, the Inspection Service, is responding to this threat by investigating and taking preventive measures against such crimes. A major portion of our consumer protection program is directed toward educating the senior citizens of this country about potential mail fraud schemes. Presentations are routinely made to various senior citizen organizations by many of the 100 postal inspectors nationwide who are assigned to crime prevention duties. We also make available, at no cost, informative pamphlets and other literature that explains some of the most common fraud-by-mail swindles. I think by educating both the young and old alike, we can reduce the number of individuals who fall victim to fraud each year.

I would like to end this brief statement by reassuring you that the Inspection Service has assigned a very high priority to both the prevention and investigation of fraudulent schemes against the elderly, and we will continue to assist the U.S. attorney's prosecution of those who operate them.

Thank you for allowing me to appear today.

Mr. PEPPER. Thank you very much, Mr. Swagerty.

Members of the panel, please accept my apology, you see a vote is on over on the floor. Mr. Wyden has gone over to vote. He will be right back in just a minute and he will resume the hearing. I will be right back just as soon as I can vote, but I don't want to miss my vote.

[Recess.]

Mr. WYDEN [presiding]. The subcommittee will come to order.

We are very, very fortunate to have Mr. Hubert Humphrey III, who has been a very distinguished Minnesota Attorney General on behalf of consumers. And, Mr. Humphrey, to introduce you, we are very fortunate to have your able colleague from our subcommittee, the Honorable Bruce Vento, who shares all of your sympathies and concerns. So I am just going to yield to my friend from Minnesota.

Mr. VENTO. I thank the gentleman. There are some forms of inflation which are not harmful, Skip. We did want to be here for a special welcome and recognition of his work both as a State senator and the State's attorney general. He has done a remarkable job in terms of advocacy for consumer issues. I had the privilege to serve with Senator Skip Humphrey in the State legislature.

I just wanted to assure that he has earned his spurs and made a name for himself, although also sharing a very distinguished name with his parent. It is a special privilege to have you before the panel and providing the insights and the type of public policy that has to, and should be, devised that deals with this very serious problem. So it is with a great deal of pleasure that I am here to hear you and welcome you to this Select Committee on Aging hearing.

Mr. WYDEN. Mr. Humphrey, we welcome you. For all of the witnesses, in the interest of time, we will put your prepared remarks into the record into their entirety. If you could perhaps summarize them so our colleagues can have some time for questions.

STATEMENT OF HON. HUBERT H. HUMPHREY III

Mr. HUMPHREY. Mr. Chairman, Mr. Wyden, thank you very much. And Mr. Bruce Vento, thank you for those very kind remarks. I will try and summarize. I did prepare written testimony that is lengthy and I believe very expressly clearly describes the extensive investigation that our office took on in cooperation with our Department of Commerce and the Insurance Commissioners. I would like to have that entered into the record.

Mr. WYDEN. Without objection, so ordered.

Mr. HUMPHREY. I have with me also assistant attorney general Mr. Tom Pursell, who was directly involved with the investigation, and I know he would be happy to respond to any of your questions with regard to the specifics.

Let me just see if I can briefly outline some of the comments from my written testimony. Our office did take on an intensive investigation into the sale of Medicare supplement insurance to Minnesota senior citizens.

In the time that I have, I would like to just tell you a little bit about our findings. The abuses that we found are what you have heard about already, Mr. Chairman, the "loading" and "twisting." I think other terms that have not been commented upon so far are "cleansheeting" and "window tracing." These are two other types of abuses.

"Loading" or "overselling" is the sale, of course, of multiple, duplicative insurance policies to a single senior. Of course, here we are not talking about three, four, five kinds of policies. Many times we are talking about 30, 40, 50—and even in one case in our investigation, 72 different policies—health and life insurance policies. The agents have a name for seniors who are overloaded with policies. They call them "mooches." It is that kind of callous approach, I think, that must be deterred, both federally and at the State level.

This subcommittee should also know that there is economic devastation, and again, the preceding commentary I think has been well stated. Let me give you just one case in our State in the investigation. An 80-year-old woman from Mankato, MN, makes the point very clear. This woman was sold 14 health and life insurance policies over a 2½-year period by agents from one insurance agency. Her only income was a $217 per month Social Security check. In 1 calendar year she spent an incredible 104 percent of her annual income on insurance premiums.

The point being made, of course, is that when she was sold that first insurance policy, she had $10,000 in the bank. By the time they were done she had no money at all and, of course, she was paying more than 100 percent of her annual income. So it is obviously a point of economic devastation.

"Twisting," as had been noted before, is what agents do when they keep persuading seniors to switch Medicare supplement poli-

cies year after year. The agents do this even to their own policies because as has been mentioned—I think it is very important to emphasize—the reason that they want those new policies, is they get a very large commission on first-year sales. The second-year renewal sales, the commissions are much less. So it is very important from the agent's point of view, if they want to make the money on the commission, to sell that new policy.

I think that is something that Congress must look into if they are going to establish any minimum standards.

This gives agents a strong incentive to sell new policies year after year.

The problem of cleansheeting is the omitting of important underwriting data such as medical history on the application for insurance. Here, again, the agents know that the companies will not issue policies to people with histories of bad health. And if the policy is not issued, the agent doesn't get the commission. Agents have an incentive to submit clean applications, or, as we call them, clean sheets.

Unfortunately, the omission of underwriting information gives the insurance companies proper grounds for denying claims. So you not only have the ripoff of the agent getting the commission, but you also have the devastation of the customer having a denied claim, and the company having a proper basis for doing that.

So, those are some of the problems that we have seen.

Now, the problem of window tracing is just plain forgery. A typical example of this is a southern Minnesota woman who was sold a Medicare supplement policy. She didn't really want it, but the agent wouldn't leave her alone until she signed on the dotted line.

When the salesman got back to the agency office, he was told that the policy could not go through—one of his colleagues had sold this woman an identical policy a few months before. When the agent reacted angrily to the loss of the commission, his boss told him, "Well, don't worry about that, there's no problem, we will give her some life insurance." He picked up a blank application for life insurance with the same company, filled it out using the information from the Medicare supplement insurance application. And he then put the life application on top of the original form, placed it against the light of the outside window, and traced the woman's signature. Plain and pure simple fraud. The forged document was sent to the company, and this senior ended up with a policy she never applied for and didn't want.

This is not an isolated case. We have prosecuted similar cases and have heard reports of many more.

Repeated misrepresentations and verbal, and even sometimes physical, intimidation of seniors are used to coerce purchase of supplemental policies. Such policies are described further in my written testimony.

Reacting to stop these abuses, we have taken actions on four fronts in Minnesota: enforcement, consumer assistance, public education, and regulatory reform.

Our enforcement efforts have resulted in criminal prosecution and conviction of the most blatant offenders, the ones who had committed forgery or theft. In addition, we assisted the Minnesota Department of Commerce, the agent licensing authority, in putting

dozens of other agents, and several entire agencies, out of the insurance business. We know that such efforts have had a great deterrent effect on other would-be con artists. But enforcement alone is not enough.

We have worked directly with seniors to help them with their insurance problems, obtaining nearly a quarter of a million dollars in premium refunds for unwanted Medicare supplement policies, and another $2.5 million returned to Minnesota consumers, almost all of them seniors, as a result of a related investigation into the fraudulent sale of life insurance policies.

We have also taken seriously the public education mission all over the State, teaching seniors and senior assistance organizations how to guard against fraud, and what factors they should take into account when buying this kind of insurance.

Finally, I have sponsored legislation at the State level which closed major loopholes in the law applicable to insurance sales. One important example is a new statute which expressly prohibits overselling. Believe it or not, until 1983 it was not illegal in Minnesota to sell someone 20 or 30 insurance policies. And I suspect that the law in most States is still lacking in this regard. Moreover, agents had no legal duty to advise their clients about the suitability of insurance purchases—all they had to worry about was selling more policies.

Mr. Chairman, that word "suitability," I think, is very reflective of the direction in which fiduciary responsibility needs to be placed. Traditionally, the agent has a fiduciary responsibility to his company. The point is, that the fiduciary responsibility and the trust relationship should be clearly identified and made direct in either Federal or State legislation that a responsibility is also owed to the customer. Minnesota law now expressly prohibits overselling and clearly places the responsibility on insurance companies and their agents to determine the suitability of insurance to senior customers.

The burden is where it should be—on the company, which has the expertise and the time to make a proper determination of the need. I think if there is nothing else that this Federal Government can do, it can establish minimum standards that will clearly place the responsibility on the companies and the agents in delineating that fiduciary relationship.

The problems persist despite our continuing efforts to stamp them out. Last year, two widespread fraud schemes were uncovered. One of these involved theft of over $140,000 from some 200 seniors, 1 of whom was over 98 years of age.

Finally, Mr. Chairman, if I could just comment briefly on why there is a continuing problem in this area. There are many reasons and I think some of those have already been pointed out. Frankly, Congress and the State governments, must bear a part of the blame, and so must the health care and insurance industries.

First of all, the Medicare system is far too complex for people to understand. If it were made simpler, we wouldn't have the opportunity for this twisting or this fast sell. So we need to simplify the system so the con artist can't take advantage of that system and sell unnecessary insurance.

Second, of course, as has been stated many times, there are gaps in the Medicare coverage which give rise to the need of this supplemental insurance in the first place.

Third, Medicare benefits are being constantly changed. So, once again, you have that opportunity, if you are going to put the con on, to make the new sale. And every time the Federal Government changes benefits, it presents unscrupulous agents with the perfect opportunity to make new sales calls on senior citizens.

And, of course, there is still no meaningful Federal regulation of the insurance industry despite the fact that many problems transcend State lines. Some State insurance regulators are poorly funded and simply cannot aggressively pursue the violators. Other States have failed to enact the necessary remedial measures such as banning the limited benefit policies which pay claims only if the insured contracts cancer, or is confined to a skilled nursing home.

Both Congress and the States have been slow to address the growing role that life insurance plays in the total picture of insurance fraud on the elderly. I think that is something that needs to be linked in because the same kind of sales tactics are used, and are used in combination, with medigap insurance.

The health care industry is partly to blame, too, because of its inability to control the costs.

The insurance industry bears the heaviest burden of responsibility. Medicare supplement companies are too eager to expand their bus nesses. They often hire agents who have histories of abusing seniors. And the companies are often reluctant to terminate these predators and report violations. In addition, the agents are oftentimes poorly trained.

I could go on much longer, Mr. Chairman, but I know that there are many others who need to speak, and there are many great concerns that need to be dealt with.

I firmly believe, Mr. Chairman, that one key component that could be of great help to the States' regulatory efforts would be mandatory minimum policy standards at the Federal level.

If we had those standards which would require a comprehensive insurance coverage, that would be very greatly helpful in all of our efforts.

[The prepared statement of Mr. Humphrey follows:]

PREPARED STATEMENT OF HUBERT H. HUMPHREY III, ATTORNEY GENERAL, STATE OF MINNESOTA

Mr. Chairman, Members of the Subcommittee, Ladies and Gentlemen, my name is Hubert H. Humphrey, III., and I am the Attorney General of the State of Minnesota. I am here today to talk about Medicare supplement insurance, a topic which the House Select Committee on Aging thrust into the national limelight with its pioneering 1978 staff study.

I bring some good news and some bad news to this Subcommittee. The bad news is that long after the Select Committee's report exposed widespread abuses in the sale of health insurance to the elderly, senior citizens in my home state continued to be shamelessly victimized by certain elements in the insurance industry. The good news is that while the problem has not disappeared, we in Minnesota have done something about it. I want to tell you now about the abuses we uncovered, what we did to correct them, and what I think remains to be done. But first, some background.

In 1981 the Minnesota Commissioner of Insurance approached members of the Attorney General's Office to talk about a problem. The Commissioner was familiar with the House Select Committee's Report, and he knew from the sheer volume of complaints pouring into his department that Medicare supplement insurance was the number one consumer problem under his jurisdiction, and perhaps in the state as a whole. Unfortunately, like most state insurance regulators he commanded a staff struggling to cope with the ever-growing demands of daily consumer assistance, complaint mediation, and routine regulatory functions. His people had neither time nor the expertise to do justice to a full-scale investigation into the sale of Medicare supplement insurance. The Commissioner asked us to help and we, of course, agreed. Here's what we did.

We first tried to put the problem into perspective. We learned, for example, that as of the 1980 federal census there were approximately 480,000 Minnesotans over the age of 65, with 600-700 citizens of the state attaining that age each week. The vast majority (some 90%) are eligible for and participate in the Medicare program.

Next, we had to understand the problems facing the people whom we wanted to help. In this regard, our main question was why this particular kind of insurance was so susceptible to fraud and abuse. The answer to that question is really a composite of different factors and circumstances, some psychological, some legal and some economic.

It is only natural that as people grow older they are more concerned about their health. Such concern is not limited to people over the age of 65 - I can tell you from my own knowledge that it applies to people in their 40's as well as those in their 80's - but such concerns loom larger as the years go by. They often come to a head at retirement age when many people who have worked all their adult lives lose health insurance benefits which they used to take for granted.

The primary replacement for those employment health care benefits is Medicare; but Medicare, as this Subcommittee well knows, is not comprehensive. It does not cover all health-related expenses. Instead it is riddled with the well known "gaps" in coverage which gave rise to the term "Medigap" insurance and the need for such coverge. Clearly, if there were no gaps in Medicare none of us would be here talking about the problems of supplemental insurance. It is not necessary to explain to this body or this audience what those gaps are; to tell the truth, the law can be so complicated, and changes so often, that I don't know if I could.

This confusion about what Medicare covers and what it doesn't contributes greatly to the problem. Crooked insurance agents exploit that confusion. Moreover, frequent changes in the law, one former agent told us, give the bad guys a perfect excuse to get into seniors' homes and sell more policies. It is enough to say that those gaps exist, that each represents a financial risk, and that a person who wants more security than Medicare offers must somehow plug those gaps. For middle income people, those with too little money to bear the risks themselves and with too much money to rely on state or federal medical assistance, Medicare supplement insurance is often the only available alternative.

Finally, everyone is aware of the soaring cost of health care. Just as people's employment benefits diminish or disappear when they retire, their incomes also fall, sometimes dramatically. As income declines, so does the need to protect an already tenuous standard of living from the crippling effects of a serious illness or injury.

None of these factors is entirely discrete: there is a constant interplay among them. For example, the more one is concerned for one's health, the more one is concerned about the means to meet health care costs. And the more the costs increase, the more important it becomes to fill the Medicare gaps.

Some of the factors making health insurance a problem for the elderly were predictable. Others, that some might have expected to be present, were conspicuous by their absence. I can say unequivocally that diminished mental capacity is not a significant contributing factor to insurance fraud on the elderly. With a few isolated exceptions, the elderly "victims" were capable people confronted with complex issues which it took our bright young lawyers months of study and research to understand. If the mere advanced age of the victims was a factor at all, it was only because when they retired their society suddenly thrust upon them a change in economic circumstances which left them at the mercy of individuals willing to prey on their well-founded fears, their innate pride, and their human anxieties.

There was one other important finding of our preliminary research. Although we commonly define the problem which we are all here to talk about today as being the sale of health insurance to the elderly, it is more. The sale of life insurance is also a significant part of the overall problem. Time and time again we saw the sale of multiple, unnecessary and essentially worthless life insurance policies. This abuse has not received the attention it deserves. In a moment, I will provide some examples of how the sale of life insurance fits into the pattern of agent abuse of the elderly.

The learning phase of our investigation lasted for months. During that time Attorney General staff members reviewed the Select Committee's 1978 Report, magazine, newspaper and trade journal articles. We researched applicable state and federal laws and the laws of other states. But most of all we talked to people. We spent countless hours on the telephone and in informal meetings with senior citizens, community organizers, legal aid attorneys and paralegals, local law enforcement officials, public health nurses, small-town senior citizen activity coordinators, our own clients in the Insurance Department, and members of the industry from insurance company executives down to agency receptionists. This process of familiarization and self-education was time consuming but, in the long run crucial to our success. Our contacts not only helped us to understand the shape of the problem but also became our primary sources of investigative leads. Just as important, by the time we began to confront individual suspects, we knew also most as much

about the practices and abuses in their industry as they did themselves.

What were the abuses we found in Minnesota? There were many. Some were flagrantly criminal, others were not even illegal. Here's what we found.

Overselling. The agents themselves call it "loading" or "loading up". Simply defined, overselling is selling a senior more insurance than he or she reasonably needs. That bland definition masks the most insidious of all the abuses in this area. I will give you some examples.

Perhaps the most heartbreaking is the case of Mrs. A of Mankato, Minnesota. Mrs. A was 80 years old when she was first contacted by investigators from my office. Unfortunately, we got there too late. During the previous 2 1/2 years, Mrs. A, whose only income was a $217 per month social security check, had been sold 14 different insurance policies 12 of them health insurance policies and two life policies. In one year she spent, according to our calculations, 104% of her annual income on Medicare supplement and life insurance premiums. All of the policies were sold by agents from one agency. When she bought the first policy, she had $10,000; those "nice young men" didn't stop coming until it was gone. Mrs. A's case is remarkable only because of her relative lack of means. In terms of the total number of policies sold, it pales by comparison with others.

Mrs. B, age 81, is a widow from Kandiyohi County, Minnesota. She is our record holder. Over a six year period, agents sold her 72 health and life insurance polciies.

Mr. C, age 84, of Minneapolis bought 32 policies from eight different agents who represented, at one time or another, 12 different insurance companies. The policies were sold over an 8-year period.

Mrs. D, now deceased, was a retired state employee from St. Paul. Her collection of 50 insurance policies was sold by 16 agents repreeenting 13 different companies.

Mrs. E, age 86 of Rock County, Minnesota spent more than $27,000 on Medicare supplement insurance in an 18-month period. This same person also paid $30,000 for life insurance policies on her grandchildren and her relatives -- policies sold by a single agent, and which her family did not even know existed.

There are dozens of stories like these . . ..

Mrs. F, now deceased, of Brown County, 27 policies, 12 agents, nine insurance companies over five years.

Mrs. G, age 89, Watonwan County - 19 policies, nine agents, nine companies in six years.

Mrs. H, now deceased, was repeatedly sold health and life policies by a relatively few agents. Her case is remarkable not for the number of policies she bought but for the fact that, according to her family and physician, it should have been obvious to almost anyone that she had Alzheimer's Disease.

Not all victims were over 65 - one 63-year-old woman in Minneapolis paid for 19 health insurance policies from these bandits during a four-year stretch. In 1981 alone she spent nearly $10,000 on insurance premiums.

The unscrupulous agents have a name for people like these -- they call them "mooches" and laugh about how easy it is to sell them insurance. Many agents kept "little black books" of names and addresses which they called their "mooch lists."

I have said that overselling is the most insidious of abuses. That is true, but it may be more useful to think of it as the most representative; the quintessential abuse, if you will. For this reason I want to dwell on overselling and make many of my observations on the general topic in this context.

First, some words about investigative techniques. Our investigation of overselling posed a number of challenges, and has sparked more questions from interested parties than any other single issue. One frequent question from others who have investigated this area is this: "How do you find your leads? And when you do find someone who is oversold, how on earth do you find all of the policies?" The answer to the first question goes back to what I said earlier about the education phase of our investigation. The countless hours that we spent talking to those who might know a victim of overselling began to pay off. They acted as our eyes and ears in the four corners of the state. We also received many tips from mainline insurance agents who stumbled across problems. Later, as our first criminal convictions and license revocations were announced, and the marginal agents got the message that we were deadly serious about putting violators out of business and in jail, we developed a growing list of inside informants.

Once we found a person who had been loaded up, the next challenge was to sort out just what insurance he or she actually had. That was easier said than done. One of the grim images in this business is that of an embarassed senior citizen placing a shopping bag full of insurance policies before an amazed investigator. We found the so-called "Shopping Bag Syndrome" to be a reality in Minnesota. But the shopping bag (or shoe box or desk drawer) often contains only fragments of the total picture: a receipt here, a cancelled check there, perhaps a glossy brochure describing a supplemental policy. Our investigators and attorneys often felt like archaeologists piecing together scattered shards of evidence to find out which agents, which companies, what kinds of policies, when they were sold, how much they overlapped, and how much they cost.

One of our first tasks, then, was to gather all the relevant information and put it into a usable form. In time, we developed a procedure which we called the "all company search." We knew that a limited number of insurance companies (20 to 30) sold Medicare supplement insurance policies in Minnesota. When we saw a strong indication of overselling, we simply sent a form request to all of them. As you can imagine, many of the inquiries came back negative; with others, though, we hit the jackpot, and we gained enough information by this procedure to justify the cost. In some cases the companies sent us records pertaining to more than a dozen policies issued to a single individual. That was information we would have missed if we had relied only on the victims' records.

You might also imagine that the insurance companies squawked about all of the extra paperwork we caused them. It took only a few sessions with company officials--presenting them with proof that their agents had sold 10 or 15 policies to a single person who also had 20 to 30 others--to convince them that they should cooperate.

With files bulging with copies of policies, applications, cancelled checks, and assorted receipts, we were next faced with the task of putting all that data into a usable form. A computer was

the obvious solution, but we didn't have one. We did, however, have an excellent work processing system which we modified to store, sort and print what we felt to be the most relevant evidence of abuse. Our insurance buyer printouts solved that problem. I have attached a reduced photocopy of one senior's record of insurance purchases as Exhibit A to my testimony. The last page of that exhibit is a key which explains the various entries. I will not go through the entire system. What we were looking for, in brief, was a way to chart the history of insurance sales to a particular individual, and to capsulize a great deal of the foundation information we would later need for trial. Putting the policies in chronological order enabled us to see the extent of duplication of health care coverage.

In reviewing this big picture of insurance buys, we also began to see that the absence of certain information was often more telling than its presence. For example, if we saw from an insured's records that he or she had written a large check to an insurance company, agency, or known agent, but we could find no corresponding evidence of an insurance policy or premium refund, we immediately suspected theft.

We found one additional use for our summary printouts that we had not anticipated. You cannot imagine the impact they had on agents and company officials whom we confronted with overselling. A jumbled sheaf of insurance policies and other records simply does not have the same "punch" as a clear and cogent listing of dozens of policies, with the same names of agents and companies appearing on every page. One of my staff members reports that he will never forget the expression on an insurance company president's face when he saw that his agents had sold page after page after page of policies, and his competitors dozens more. The effect on agents was equally devastating.

How does a senior citizen come to be a victim of overselling? Earlier I told you about some of the factors which make the sale of health and life insurance to senior citizens susceptible to abuse. I don't need to repeat them except to say that all contribute heavily to overselling. I do, however, want to expand on certain characteristics of the victims and the perpetrators because there appears to be a clear profile of each.

We found the typical victim to be between 70 and 85 years old, often recently widowed and dealing with financial or business affairs for the first time. Most commonly he or she lives alone. Some insurance industry members' knee jerk reaction to victims of loading up is that the seniors were the real abusers -- that they were "gambling" with their premiums in order to get paid many times over for the same accident or illness. We found no instance whatsoever in Minnesota of any such practice or intent on the part of seniors who had been loaded up. Instead, we found the victims to be conscientious and honest citizens who, when a bill arrives, see that it is immediately paid. They are proud people concerned about becoming a financial burden on their families, friends, or neighbors should they become hospitalized, confined to a nursing home, or die. All too often they are lonely people, eager for any human contact and grateful for a visit from an attentive young agent who pretends to have their best interests in mind. Some agents so successfully ingratiated themselves with their victims that they persuaded them not to cooperate with "those guys from St. Paul" who were "trying to stir up trouble."

Perhaps most ironically, the typical victim of loading up is reluctant to admit that he or she may have been duped; afraid to appear incompetent or unable to cope alone. Thus, we know that despite our best efforts we were unable to help many of those who

needed it most, precisely because they do not want to admit to their need. There is nothing extraordinary about these people: they could be anyone's parents, grandparents, aunts or uncles. They merely had the misfortune to be the targets of crooks who knew how to skillfully exploit their very human weaknesses.

Who were the crooks? Here again, a profile emerged. Most of the unscrupulous agents were young, in their twenties. You must understand that to be a traveling Medicare supplement salesman is to cling to one of the lowest rungs on the insurance industry's ladder. It is very much an entry-level position, often occupied by people with minimal training and minimal appitude for a job which, to do it right, requires a grasp of some relatively complicated issues. Apart from the few hours of classroom instruction needed to get a license, their only training is informal -- a day or two on the road with a more experienced agent, who as likely as not, teaches the new recruit all the wrong things.

There is a fair amount of turnover among these new agents. Some, of course, simply can't make a living in sales. Others drop out in disgust at the tactics of their colleagues. Others still get what experience they can and move off to sell more respectable lines of insurance. Many of those who remain in the Medicare supplement business for any length of time, however, become calloused to their jobs and their clients, as people can become calloused to almost any kind of human misery. Or, perhaps, they simply had no moral sense to begin with.

They often wear expensive clothes and drive flashy new cars which they can barely afford. Many have some formal education after high school; few have completed a degree. They often turn to selling Medicare supplement insurance because they can't make it in any other white collar job. These, then, are the people who prey on our senior citizens and load them up with unnecessary insurance.

I do not need to tell you the economic loss that results from the sale of dozens-of overlapping health insurance policies. Most of those policies have "coordination of benefits" clauses which, in effect, render duplicative policies worthless. In any event, every expert we consulted agrees on one thing: a person who chooses to plug the gaps in Medicare with health insurance, needs one good, comprehensive Medicare supplement policy and nothing more. It is not necessary nor does it make economic sense to purchase a second Medicare supplement policy, nor to supplement the supplement with any of the limited benefit or "dread disease" policies which pay claims only in the event the insured contracts cancer, has an accident, is confined to a hospital, is admitted to a nursing home, requires in-home health care, or is injured in a plane crash. Minnesota law now prohibits the sale of such policies to persons eligible for Medicare except in very limited circumstances. That prohibition has vastly simplified the health care equation for Minnesota seniors, and has channeled their premiums into policies which give them more return for their dollars.

It is useful to remember who the Medicare supplement crook is not. He is not the long-time, neighborhood, or local agent. He is not a member of one of the agent professional organizations. He is not the respected small town business person. One of the things which struck us as most mysterious was why senior citizens, especially in the small towns or cities in Minnesota, did not buy their supplemental health insurance from the same agent or agency where they got their automobile or homeowners policies. In fact, it became increasingly clear that the respected, local agent, was conspicuous by his absence from our records. We approached a number of such agents to find out why. Their comments revealed a failure within the insurance industry:

"Wouldn't touch it with a ten-foot pole."

"Not worth my time."

"The companies I represent don't offer that stuff."

"My company has a good Medicare supplement policy, and they give great service. But it's much more expensive than the cheap stuff sold by the fly-by nighters."

"I tried it, but every time I placed a policy some guy came along and knocked it out. It's hard to compete with people who don't play by the rules and I'm sick of trying."

These remarks are typical of ones made to us in informal conversations with the many good insurance agents in Minnesota. They reflect the fact that Medicare supplement insurance has long been the "bad boy of the industry" which too many legitimate agents and companies have abandoned to anyone who will take it. Because of the lack of adequate enforcement and regulation, and the lack of economic incentive for the good agents to compete with the bad, abuses in the sale of health insurance to the elderly have, in effect, become self-perpetuating.

I have said that overselling is the quintessential abuse in this area. In part that is because, without exception, we found serious overselling to be coupled with other illegal practices. The sad fact is that when some agents found a good mooch, they just couldn't lay off; they'd do anything to sell policies and get their commissions. The interrelationship of overselling and other abuses will become clearer as I discuss each separate illegal practice in turn.

Perhaps the most amazing observation of all about overselling: under the state of the law as we found it when our investigation began, overselling -- even selling 50 policies to a single person -- was not illegal. Even when we could prove it (and that was often difficult because the many agents and companies involved usually could disclaim any knowledge of the others' activities), overselling did not violate any federal or state statute or administrative regulation. To prosecute overselling as such, we had to develop new legal theories to tie the manifest abuse to the inadequate existing law. For example, we argued that overselling was fundamentally "dishonest" under our insurance agent licensing law which prohibits agents from engaging in dishonest conduct. Or, we maintained that selling a duplicative policy was implicitly a misrepresentation, again prohibited by the licensing state law, because by selling the policy the agent implicitly promised that it was worth something, when in fact it would return no economic benefits to the senior at all.

Despite the gaping holes in Minnesota law, holes which I am sure still exist in most states, we had two things going for us. One, as I have already said where there is gross overselling there is almost always another, more easily proved violation to be found. Two, even if it wasn't illegal, it was wrong, and everybody knew it.

How do people become victims of gross overselling? To answer this question it is necessary to examine the marketing and employment practices of Medicare supplement insurance companies and agencies. Who knows how someone first gets his or her name on a sales or customer list? One may respond to a mass-mailed letter, answer a phone call from some agency "boiler-room," tear out a postcard in the Sunday supplement, or see a retired TV personality on a commercial and dial the toll free number "for further

information." Or, the first contact with a Medicare supplement crook may be something akin to an accident of birth. A former agent whom we interviewed early on bragged that he and his friends would check into a small town motel and head straight for the phone books. There, he said, they looked for people with "old-sounding names" and prepared to start making "cold calls" the next day. Whether or not those cold calls led to a sale, the agents asked for the names of friends or neighbors who might be interested in insurance. In this way, according to our informant, the agents would work a small town until the leads dried up.

However the first contact occurred, a senior who bought one policy was thereafter fair game. At a minimum, insurance agency personnel would call or visit that buyer again in a year to "review their coverage," and try to sell them either a more expensive policy or some new type of coverage. For example, if the insured had a comprehensive Medicare supplement policy, wanted to keep it, and didn't want another, the agent would attempt to sell a cancer policy, a daily hospital room payment policy, or nursing home coverage. Or, if the senior refused to buy more of any type of health care coverage the agent would pitch life insurance instead. With one or two policies in place, a snowball effect began.

The snowball got larger because of the high turnover of agents within agencies and because agencies themselves frequently switched Medicare supplement insurance carriers. At the first sale, the senior who was, at least at one point, a willing buyer, became an impersonal "lead." Agents, agencies, and companies jealously guard those leads, each regarding them as their own property. Each had its policyholders' names in a file as a source of future income. As soon as Agent Number One sold a policy, his client's name went on record in the agency. When that agent left one agency for a better deal elsewhere, he took his leads with him and would try to sell a new policy, usually on behalf of a different company. If that sale occurred, the second agency got the lead as well, as, of course, did the new company. At that point, of course, all the agents at both agencies had at least potential access to the buyer's name.

At the same time, the former agency may have severed its relationship with the first insurance company which, upon retaining a new general agent in the area, promptly turned over the names of its existing customers to a third agency. You can easily see how the snowball grew. As long as the senior kept saying yes, the agents kept selling policies. It didn't matter what the policies were, as long as there was money in the checking account. Even when some seniors began to say no, they continued to be harassed. One Minneapolis woman told us how, after nearly 50 policies, she simply refused to answer the door. Nevertheless, "they kept coming the first week in the month, right after I got my social security check," and didn't give up for many months thereafter.

Sales leads are so important to the Medicare supplement bandits that we found a thriving black market in sales leads. We heard constant complaints from the crooks themselves that so-and-so had left the agency with a drawer full of "lead cards," and was selling leads instead of insurance. One of the worst violators kept an alphabetized "black book" of the type commonly used to keep important names and addresses. Instead of being organized by his clients' last names, however, this book contained an alphabetical listing of small towns in Minnesota. Under each town, in turn, were the names of his "mooches." Wherever he might be in the state, he knew he could make the payment on his new Corvette. He just looked at the map, flipped open his book, and sold a policy (or two or three) to the nearest mooch.

Enough about overselling. On to the other abuses.

Twisting. Twisting (or "rolling") is another abuse, which, although not unique to the Medicare supplement industry, is most common in that line of insurance. Our definition of twisting is this: the unnecessary replacement of an existing Medicare supplement policy. So, what's wrong with replacing a Medicare supplement policy? you might ask. The answer is "at least three things."

To begin with, you must understand that a health insurance contract is not a company's unconditional promise to reimburse every medical or hospital expense incurred during the life of the policy. On the contrary, most policies limit payment for "pre-existing conditions." Usually the policies will exclude from coverage those claims which resulted from a sickness or injury requiring treatment during a stated period before the policy goes into effect. Usually, such claims are ineligible for a stated period of time, such as the first six months of the policy's life. In severe cases, the health insurer may, by an addendum to the contract, permanently exclude certain conditions from eligibility for payment.

There is nothing inherently wrong with pre-existing condition limitations, or "waiting periods" as they are often called. Insurance companies gamble on risks, they don't bet against sure things. Otherwise, a person could break his or her leg, and then take out insurance to pay for the expenses. The reason "waiting periods" and the replacement of health insurance policies are bad company is because the waiting periods can make for interruptions in the continuity of coverage.

An illustration: You, a consumer, have had insurance with company A for years, and the company has faithfully paid the claims resulting from your continuing back problem. If you decide to buy a new, improved health insurance policy from company Z, you must take into account that company Z will not pay for your bad back until six months after the effective date of the policy. Therefore, if the new policy goes into effect the same day the old one expires, you will go six months without coverage for your continuing problem -- the one condition which makes it worthwhile for you to have health insurance in the first place. Your alternative is to overlap the policies during the six-month waiting period. That way, company A will continue to pay for your bad back while the two companies, whose policies prohibit double payment for the same claim, will split any other expenses you may incur during the waiting period. Of course, for that length of time you are paying twice as much as you need to for health insurance.

That is the first problem with twisting. Even if the new policy is better, if a person has ongoing health problems he or she will have some economic loss. He or she will either lose benefits through gaps in coverage, or pay for temporarily duplicative insurance policies.

Twisting also leads to loading. People who buy policies intending to have the minimum necessary duplication often end up keeping both. They may decide on their own that if one policy is good, two are better. They may simply do what many of us do, that is, resign themselves to paying whatever bills come in the mail with hardly a second thought. It is just as likely, though, that when the insured fails to renew the policy on time, or attempts to cancel, the insurance company sends out a notice to the general agent of record. That general agent will send someone out to talk to the senior, and try to persuade him or her to keep both, or to keep the first policy and get rid of the second one instead. Meanwhile, the agent who originally sold the first policy may now

represent two entirely different companies. Even though he works for another agency, his "tickler system" says the first policy is about to expire. Thus, he too may pay the senior a visit and try to "knock out" the original policy and the first replacement, or simply add a third. And so on, and so on. . . . Remember that snowball?

Finally, the repeated calls of salesmen trying to replace others' policies, or their own policies with new ones, or to push "upgraded versions," or to sell new kinds of insurance, are simply annoying and harassing. The constant pressure of repeated sales calls can wear down all but the most sales-resistant customer.

Falsification of applications. I told you about loading and twisting, now I'll tell you about "cleansheeting." In my remarks about twisting I alluded to the fact that insurance companies are understandably selective about the risks they assume. Every company places some underwriting restrictions on the issuance of its policies. A company's principal source of underwriting information on its prospective customer is the application for insurance. Those applications, which are filled out by the agent at the point of sale, usually include the applicant's name, age, existing insurance policies, next of kin, and at least a brief medical history. Of course, the company underwriters look most closely at the medical history. The fewer the indications of ill-health -- the "cleaner" the "sheet" -- the more profitable the policy is likely to be. Of course, agents like nice healthy customers too. If the medical history portion of the form is full, and there are lots of little questionnaire boxes checked "yes," the underwriters may reject the application. And if the policy is not issued, the agent gets no commission! Don't forget that commissions are the name of the game, so agents have a vested interest in submitting clean applications.

Omitting adverse underwriting information is a sore temptation to a crooked agent. The problem for the consumer is that if a substantial claim is incurred, the company may investigate the claim, and go back to the underwriting data on the application. If it finds false information, or material omissions, the claim will be rejected. The knee jerk response, again, is that the consumer, not the agent, is the cheater. In our experience, the elderly insureds never knew that underwriting data was being falsified or omitted. Instead, we found agents filling out accurate applications at an insured's kitchen table, then returning to the office to make up an entirely new document to send to the company. It is true, at least in Minnesota, that a copy of the application as actually submitted to the company will be stapled inside the policy which the insured eventually receives. But I wonder how many people in this room pore over the applications for insurance inside their policies to make sure that they are accurate line for line.

Health history information is not the only kind of application data which may be falsified. Changing a single digit on an age or date of birth can make an applicant years younger, and result in the issuance of a policy which could not otherwise have been sold.

Finally, cleansheeting too often goes hand-in-hand with overselling. Many companies' applications require a listing of the applicant's existing health insurance policies. Underwriters are reluctant to issue a policy to someone who already has many, fearing that such people may try to receive multiple payments for a single claim. Therefore, we found, some agents omitted known policies, especially if they themselves sold most or all of them.

Misrepresentations. Misrepresentation is undoubtedly the most common of abuses. It is also among the most difficult to prosecute, however, because false promises frequently do not come to light

until the insurer denies a claim which the senior citizen expected would be paid. By that time, memories have faded and it is difficult to reconstruct who said what to whom. The variety of specific misrepresentations made in connection with the sale of Medicare supplement insurance is limited only by the ingenuity of the crooks who make them. There are some statements, however, which are "classics" in their genre.

> "This policy will cover everything that Medicare doesn't pay." In our experience, this statement is always false. Moreover, even if a particular policy covered all the familiar Medicare gaps, one person's idea of "everything Medicare doesn't cover" may be vastly different than another's. Among the common health related expenses which concern seniors are those for eyeglasses, hearing aids, and dental work. Medicare does not pay for all of those expenses, nor, to our knowledge, does any single insurance policy.
>
> "This policy will take care of all your nursing home expenses." This may be the most common misrepresentation of them all, and it is a subtle one. The agents know full well that many people think of "nursing home" care as including long-term custodial living arrangements, while the policies typically cover only skilled nursing home care in Medicare approved facilities.
>
> "Hello, I'm here to explain your Medicare benefits as a free service." Many a Medicare supplement salesmen got his foot in the door by pretending to be a Medicare representative with only the most altrusitic of motives for an unannounced call or visit. There are many variations on this theme. "Medicare sent me out here to talk to you about your health protection." "I'm licensed by the state to explain Medicare insurance."
>
> "Your current insurance company is about to go out of business, so I wanted to stop by to give you a chance to buy a policy from a safer company." Some insurance companies, of course, do go out of business but this is obviously a scare tactic used by agents twisting policies.

Intimidation and coercive sales tactics. How do some Medicare supplement salesmen close a tough sale? We heard many stories of agents simply refusing to leave a senior's home until he or she signed on the dotted line. In more egregious cases agents became verbally abusive, saying "Why do you want to talk to your daughter about this? Can't you make up your own mind? You're not senile, are you?" Or, worse still, a few agents would shout, scream, pound on the door, throw books and ashtrays on the floor, or even physically intimidate seniors until they got their way. But the most common coercive or intimidating sales method is the simple scare tactic. "You can never have too much health insurance." "If you don't have enough insurance, it's your family that will bear the burden." "Who knows what Congress will do with Medicare next year?" "You don't want to go on welfare, do you?"

Theft. Theft of insurance premiums can take several forms. One example of a blatant rip-off occurred in Nicollet County, Minnesota. An agent made his sales pitch to an elderly couple, who agreed to buy a policy. They made the mistake, though, of handing over a $500 cash premium. They thought everything was fine -- the agent even

gave them a receipt. Of course, the name on the receipt was fictitious and "that nice young man" pocketed the money. We were able to use our contacts and informants, by the way, to identify the agent and hand him over to the Nicollet County authorities.

A second, less blatant kind of theft occurs when an agent collects premiums and applications for insurance from customers, forwards the applications to the proper insurer, but fails to remit the premiums. This kind of theft is more legally ambiguous because Medicare supplement insurance companies often permit their agents to work on a "net premium" basis. That is to say, the agents are entitled to deduct their pre-determined commission from the payment actually received from a customer, and send only the company's portion of the money, "the net premium," to the insurer. The agent's failure to remit the net premium, is, in the first instance, a breach of its contract with the insurer. It is only when the problem has already gotten out of hand and the agent's intent to convert the money to his own use becomes manifest, that criminal or administrative/licensing proceedings can begin.

We have also seen instances where agents collected money and took proper applications from seniors, but failed to send either to the insurer. Instead, they just pocketed the money and threw away the application. This is obviously a dangerous practice for the agent, who has left a paper trail in the form of the senior's check records. It is not surprising, therefore, that this particular brand of theft is also associated with overselling. We found that only when agents believe that a senior has so many policies that he or she won't miss one more, that the agent feels safe in such a blatant omission.

Another swindle also involves falsifying information on the application for insurance. When an agent sells a policy, he almost always collects a premium on the spot. The amount of that premium depends on the product, but for any given policy a prospective insured will usually be able to choose a three-month, six-month or full year's prepayment. Agents and companies, of course, prefer the latter and, in our experience, it is as common as not for people to pay an annual premium up front. This presents an agent who is short of cash with a perfect opportunity to skim a little off the top. All he has to do is alter the application to reflect receipt of a six-month, or three-month prepayment, instead of a full year's. Then the agent submits only half (or a third) as much premium to the company as the customer actually paid. By the time this theft is discovered the agent may have spent all the money. Naturally, we hold the insurance company liable for the loss.

Finally, the most cleverly concealed theft of all -- milking money from seniors under the guise of "loans." Time after time we found unmistakable evidence that agents abused their positions of trust to ask for loans. You may not be surprised when I tell you that, viewed objectively, the seniors probably needed a loan a lot more than the young con artist. In the worst case, an agent "borrowed" an 80-year-old Minneapolis man's entire life savings of $20,000. The agent, who was about 6'4" tall and looked like something out of a science fiction movie, had a tattered loan agreement allegedly signed by the frail, octogenarian "lender." We filed theft charges, but about two weeks later the victim died. It was not easy to have to dismiss that complaint. We eventually put that agent out of business in Minnesota for another infraction.

A somewhat different case demonstrates the interrelationship between overselling and this brand of theft. An 88-year-old nursing home resident had been courted attentively by a young agent for a period of years. During that time, he used his friendship with the

woman to sell her five health insurance policies in addition to the 22 other health and four life policies she had purchased during the previous none years. At the same time, he systematically overcharged her for the policies and pocketed the overcharges. When a family member questioned the amount of premiums her mother-in-law was paying, and the discrepancies between amounts collected and actual premiums, the agent produced his promissory note in the amount of $1,000. You can see how easy it is for an agent to muddy the legal and factual waters in such situations, at least enough to avoid criminal prosecution.

Forgery. I have already told you about loading, twisting, and cleansheeting. Now I want to tell you about "window-tracing" and "Rembrandting." Window-tracing and Rembrandting are insider words for forgery, which appears to be the crime of choice among Medicare supplement insurance salesmen. The documents which are most frequently forged or altered are insurance applications and related forms. I have already mentioned one of the principal motivations for this practice, namely, the falsification of underwriting data. There is another prototypical situation in which forgery occurs, and that is policy switching.

Here's how it worked in two cases which we successfully prosecuted.

Agent L, a field agent employed by a suburban Minneapolis general agency, picked up his weekly supply of "lead cards" from his general agent on Monday. Each card had the name, address and telephone number of a senior citizen who had either previously purchased insurance from the agency or who had responded to a mass mailing or telephone marketing campaign. Significantly, the cards did not list previously purchased insurance. The agent took the cards, hopped into his brand new red sports car and headed south out of the Twin Cities to work the southern tier of Minnesota counties.

In town after town he struck out. The prospects weren't home, didn't want insurance, or wouldn't even let him in the door. Finally, he stopped at a farmhouse near the Iowa border. There, Mrs. Smith (not her real name) was hurriedly packing for a trip to visit her daughter in California. She did not really want to talk to this salesman, but he would not leave her alone. Finally, she agreed to buy a Medicare supplement insurance policy, signed an application, wrote him a check for a $448 annual premium, resumed her packing, and forgot about the incident.

The sale to Mrs. Smith was the agent's only one that week. He returned to the agency on Friday afternoon to "turn in" his business, which consisted of just that one application and check. He knew that his boss would pay him his share of the commission that afternoon, and he was relieved that he would be able to make his car payment. But the agency office manager had a surprise for him: "I can't pay you on this one," she said. "We sold her an identical policy three months ago and you know the company won't issue a duplicate."

The agent threw a tantrum. He had spent the whole week on the road and now had nothing to show for it. But he knew that the office manager was right -- the insurance company would not issue a completely duplicative policy. At the high point of the agent's tantrum, his boss, the general agent said "Calm down, we'll give her some life insurance." He then pulled a blank application for life insurance with the same company out of a drawer and filled it out, using the information contained on the health insurance application. He then placed the life insurance application, complete except for Mrs. Smith's signature, on top of the genuine health application,

put both against the strong light of an outside window, and traced her signature. (No one in this agency was artistic enough to perform a free-hand forgery, i.e., they couldn't "Rembrandt" it.)

The general agent had carefully chosen the face amount of the life policy so that its premium was a few dollars less than that of the Medicare supplement policy. The office manager later wrote Mrs. Smith a nice note, with a check enclosed, telling her that Agent L had inadvertently collected too much premium.

The victim in this case received her policy in the mail and, as most of us do, just stuck it in a drawer. It was not until the agent, whom we confronted with other wrongdoing confessed to this crime and a state investigator paid Mrs. Smith a visit, that she realized she had received a life insurance policy which she never intended to buy.

Another example, this one from south central Minnesota, will suffice to illustrate the point. Agent G, from the same general agency referred to a moment ago, sold a Medicare supplement policy to a woman in Sibley County, Minnesota. He too returned to the agency only to find that, because of incomplete information, he had sold a duplicative policy. Again, the agency owner suggested life insurance, this time from a completely different company. But he and his field agent were greedier. For approximately the same amount of premium, they filed an application for <u>six months</u> worth of life insurance. What these crooks didn't count on was an alert senior who promptly went to her lawyer's office with the strange policy she had never purchased. Largely as a result of these two cases, both field agents and the general agent were convicted of forgery, the agency itself was put out of business, and most of the agents therein lost their licenses

These, then are the major abuses which we uncovered in the sale of health and life insurance to senior citizens in Minnesota. There are, of course, others such as "forgetting" to make premium refunds and "losing" policy cancellation requests. But the practices I described in detail are the worst, and the most common. They were not isolated misdeeds. For every crime we were able to prosecute we heard stories and rumors of dozens more. I want to stress that all of these instances took place after the House Select Committee's 1978 Report, and after passage of the Baucus Amendment which set general federal guidelines for Medicare supplement insurance policies.

Just how widespread is the abuse of Minnesota's seniors? During a three year period, we focused on some 15-20 insurance agencies which, at one time or another, employed over 200 field agents and represented 20-30 companies. A small fraction, clearly, of the total insurance industry in Minnesota, but a very large fraction of the Medicare supplement industry. At the height of the investigation new complaints seemed to pour in from all directions, and victims seemed to be everywhere. I cannot give you exact numbers as to how many people were the targets of some form of unfair sales practices by Medicare supplement agents. We found hundreds of people who had been oversold to one extent or another. Fortunately, the outright crimes of theft and forgery were much less common. But our sources of information reported that such relatively minor infractions as misrepresentations were too numerous to count. Add in the people who bought insurance from unlicensed agents, who had their policies "twisted" at least once, and those who were subjected to coercive sales tactics or misleading advertisements but ended up saying "no", and you have a significant percentage of the insurance-buying senior citizen population. Moreover, if our victim profile is accurate, we probably missed

helping more people than we found because, as I have said, those who needed our help most were often the last to ask for it.

The Minnesota Commissioner of Commerce (successor to the post of state Insurance Commissioner) reports that Medicare supplement insurance complaints continue to run second only to complaints and inquiries about automobile insurance. Last year his department uncovered two Medicare supplement fraud cases as bad as anything we observed in the late 70's and early 80's. In one of those cases, a southern Minnesota agent allegedly misappropriated over $140,000 in Medicare supplement premiums from some 200 senior citizens, one of whom was 98 years old.

What did we do about the shocking abuses we found in the sale of Medicare supplement and life insurance to Minnesota's senior citizens? I have already referred to some of our enforcement efforts. Those efforts led to criminal convictions of about a dozen of the worst offenders from 1982 to 1985. In addition, my office, as attorneys for the Department of Commerce, has assisted that agency in revoking or suspending the agent licenses of scores of Medicare supplement violators. Our close monitoring of the insurance problems of senior citizens also put us on to the fradulent sale of so-called "estate conservation" life insurance policies which were being marketed in the state. Briefly, the "estate conservation cases" involved extremely expensive life insurance policies which the companies and their agents sold as high-yield investments. The resulting actions lead to record civil penalties being assessed against two of the insurance companies, the revocation or suspension of more than 100 agent licenses, the outlawing of all similar policies in Minnesota, and the refunding of approximately $2.5 million in insurance premiums to Minnesota buyers. Minnesota was the first of many states to take significant action against the companies involved, and assisted others by providing information and insight into the problem.

Aggressive enforcement through every available legal avenue was for us, and must always be, the cornerstone of any effort to clean up the Medicare supplement insurance business. We know from talking to our contacts that our enforcement efforts not only put the worst offenders out of the business, but also had a substantial deterrent effect on the rest. But enforcement alone is not enough. We have also helped our senior citizens through consumer assistance, by public education, and by pushing for necessary legislative and regulatory reform.

We regard consumer assistance as one of our most important functions. The attorneys and legal assistants on my staff respond to dozens of letters and phone calls each week from senior citizens and their families. Since 1983 we have recovered nearly $250,000 which Minnesota seniors paid for Medicare supplement and life insurance. That figure, incidentally, is above and beyond the $2.5 million refunded in the estate conservation cases. In addition, the Minnesota Department of Commerce responds to thousands more complaints each year from Medicare supplement buyers.

Public education is also an important weapon in our arsenal against insurance fraud. Since our investigation began, I and other attorneys on my staff have spoken to interested groups of insurance agents, attorneys, and, of course, senior citizens, all over the state. We have written numerous newspaper and magazine articles, and cooperated with the media to make seniors, law enforcement officials and others aware of the issues. We have also presented our essential findings to the Committee on Elderly and the Law of the National Association of Attorneys General. After that presentation, several state attorneys general expressed interest in

our enforcement program and in proposing remedial legislation and regulations similar to those sponsored by my office in recent years.

Naturally, our primary education mission is to affected seniors themselves. Besides giving them a nutshell version of what I have just presented to this Subcommittee, we also tell them some ways they can protect themselves. Here are what we believe to be the most important steps a senior citizen can take to protect himself or herself against insurance fraud. I will tell them to you as we tell them to our seniors.

First, don't let anyone sell you insurance you don't want or can't afford. It's not always easy to say "no," but it sometimes must be done. If you can't say "no" on the spot, don't hesitate to stop payment on a premium check you wrote for an unwanted policy. If an agent insists even after you stop payment on your check, call your state attorney general, insurance commissioner, a friend, local insurance agent, attorney or other person for help.

Second, if you buy a Medicare supplement insurance policy, or any other kind of policy for that matter, review it carefully to make sure it is what you want. Also, take a close look at the copy of the application which should be inside of the policy. Verify that all of the information is correct. If there is a problem, especially if the application appears to have been changed in any way, call for help.

Third, if you get a visit from an insurance agent whom you don't personally know, make sure you get his or her name and ask for proper identification.

Fourth, don't give cash to an insurance agent you do not personally know. Writing a check for any consumer purchase rather than paying for it with cash, will give you a valuable record which you may later need.

Fifth, don't relinquish (to anyone) your insurance or other financial documents -- policies, cancelled checks, receipts, correspondence, etc. -- without first obtaining a complete and itemized receipt. Make sure that the name, address and telephone number of the person taking the documents is on that receipt and that he or she signs it. Keep these and other valuable records in a safe place.

Sixth, don't pay insurance premiums too far in advance. Your circumstances and needs may change in the future.

Seventh, don't hesitate to report to the authorities (your state attorney general, insurance commissioner, or a local law enforcement agency), any suspicious conduct by insurance agents.

Eighth, do some basic homework. In order to make the most intelligent decision about supplemental health care you will need to understand a bit about Medicare, its relationship to private insurance, and

other governmental benefits which may be available to you.

Ninth, consider the alternatives to Medicare supplement insurance. One prime example is the health maintenance organization which in many areas of the country provides a viable alternative to traditional health insurance. In the final analysis, you are the best judge of what you need and want.

Last, and perhaps most important, if you do have a problem, if you have been oversold or treated unfairly in any way, please don't be afraid to discuss your situation with relatives, friends, your lawyer, or anyone else you know and trust. Know that you are not alone, that many bright and able people have had the same problem. Know too, that there is always someone willing to help if you will ask.

I'm happy to say that our consumer education efforts have paid off. Now, when we speak to groups of seniors around the state, we find them generally much more aware of the problems and pitfalls of Medicare supplement insurance.

The fourth and final corrective action we took against abuses in the sale of health and life insurance to the elderly was to examine Minnesota's laws to see where change was needed. I will summarize the most important reforms and tell you what has worked and what still needs to be done.

The essential legislative foundation for adequate regulation of the Medicare supplement insurance business was actually laid before our investigation began. In 1981, the Minnesota Insurance Department proposed, and the state legislature enacted, a number of laws specifically governing Medicare supplement insurance. The most important feature of the 1981 act was that it set minimum standards for supplemental policies sold in Minnesota. The act, which the insurance industry unsuccessfully challenged on constitutional grounds, established four categories of Medicare supplement policies and assigned policy ratings (1 plus, 1, 2 and 3 in descending order of inclusiveness) for easy comparison of benefits. Policies within each category can and do contain different benefits, but each must meet certain minimums with respect to the Medicare gaps.

An equally important feature of the Act was that it prohibited the sale of other kinds of accident and health insurance to seniors on Medicare. In other words, companies and agents could no longer sell the "dread disease" and other policies of limited coverage and even less utility to Minnesota seniors; only approved, comprehensive health insurance policies, specifically tailored to Medicare copayments and deductions, are permitted. At one stroke, this provision solved the problem of under insurance for people who relied on limited benefit policies as their sole back-up to Medicare, only to find them worthless. It also alleviated overselling. Agents could no longer confuse seniors with the necessity of buying nursing home, home health care, cancer, accident, daily room benefit and similar policies to supplement the supplements.

Unfortunately, while the 1981 act was a firm foundation, it did not address all the problems. I sponsored corrective legislation in 1983 to close the major loopholes. The first proposal addressed an enormous deficiency in the law, a deficiency which I have already referred to: the fact that overselling was not illegal. Minnesota law now limits the number of Medicare supplement policies which an

agent or company can sell to one individual. As I have already testified, there was unanimous agreement among the experts we consulted that no senior needed more than one good, comprehensive policy. At the same time, however, we recognized that there are valid reasons for replacing an existing policy. Therefore, the new law provides that only one Medicare supplement policy can be sold to a person, provided that a second policy may be placed and duplicate coverage maintained for to cover any waiting periods and ensure continuity of coverage for any pre-existing conditions. The law puts the burden on the insurance company to police its agents. It requires the insurer with an illegal, duplicative policy to refund the consumer's money, whenever requested, or pay the claims on such policy. The senior consumer has the option of choosing which he or she wants.

I am happy to say that the effect of this law has been to dramatically reduce the incidence of overselling in Minnesota. Even egregious overselling cases now involve 4, 5 or 6 policies, not 40, 50, or 60.

We puzzled long and hard over potential solutions to the related problems of windowtracing and cleansheeting (forgery and falsification of applications). One day, one of the investigators was struggling with the problem of proving that a particular application was forged, and thinking wishfully that it would be nice to have the original writing as evidence. That document, of course, had long ago been destroyed. "Wouldn't it be great," he said, "if these agents left copies of the original applications with the customers at the point of sale?" His idea is now codified in the Minnesota Statutes. When selling a health or life insurance policy to a person age 65 or older, the agent is responsible for providing a signed and completed copy of the application to his or her client. No longer can an agent alter an application without leaving a paper trail to convict him. For the price of a piece of carbon paper for each transaction, subsequent alterations of the applications was virtually eliminated.

For many years Minnesota consumer protection laws have required telephone and door-to-door salespersons to identify themselves, their companies, their products, and to reveal that they were indeed trying to sell something, before making a telephone or in-person sales pitch. Because insurance sales practices have historically been regarded as "different," insurance sales were exempt from the consumer laws. As a result, many of the tales which agents told to gain entry to a senior's home were effective and difficult to prosecute as misrepresentations ("I'm here to explain Medicare as a free service"). Now, insurance agents must make the same up-front disclosures as those who sell any other product.

The new laws also require agents to deposit premiums in agency business accounts. These business accounts are not "trust accounts" in the strict sense, but the requirement at least permits some tracing of funds and raises a presumption of irregularity if money is not deposited as it should be. Before, agent-company contacts were the only applicable law.

As we gained even more experience during the course of the investigation, it became clear that we had overlooked some necessary remedial measures. In 1984 we suggested to the Commissioner of Commerce (who was just as appalled at these abuses as we were) some ideas for regulations which he ultimately adopted using his department's authority. Those regulations, among other things, prohibit agents from stealing money from a client under the guise of a loan, require timely delivery of insurance policies and premium refunds, provide punishment for companies and agencies which cover

up the illegal conduct of their agents, and require agents to assess the suitability, or appropriateness to their clients, of Medicare supplement policies, life insurance and annuities. In other words, this rule requires agents to consider buyers' needs for coverage, not just their needs for commissions.

We believe that the combined effects of aggressive enforcement, consumer assistance, public education and regulatory reforms give Minnesota the best record in the nation on the issue before this Subcommittee. I have already told you, though, that problems persist. The three most intractable areas of abuse are twisting, misrepresentation, and theft.

Why do agents twist policies? And why, for heaven's sake, will one agent replace his own policies time after time? Part of the answer is simply that competition in this particular line of insurance has always been fierce. The other part of the answer, though, has much to do with the commission structure paid on Medicare supplement policies. We found general agents earning up to 80% of first-year commissions in Minnesota, with a 60% commission being closer to the norm. General agents, of course, must pay their field agents who, in our experience, typically received 30 - 45% of the total first year take.

In the second year, however, renewal commissions drop dramatically to around 10-15% for the general agent and a mere pittance to the actual salesperson. These already low renewal commissions diminish even further over time. In short, it pays a great deal more to sell new policies than to retain old ones. If commission structures were more in line with those typically paid on property/casualty or other lines of insurance, there would be much more incentive for agents to let policies stick than to twist them year after year.

Misrepresentation may be the most intractable abuse of all. To some extent it is unavoidable. After all, unless someone's taperecorder is going, or the agent is foolish enough to make a misrepresentation in writing, or unless an agent has made the same misrepresentation to a number of customers who all complain about it, misrepresentation is very difficult to prove. Better agent training, including pre-licensing and continuing education requirements, may alleviate inadvertent misrepresentations. Also, anything which can be done to prevent twisting will also remove a major cause of misrepresentations.

Finally, theft is a continuing problem. It is probably true that as long as there is money there will also be someone who steals it. Medicare supplement insurance companies, however, should not permit their agents to operate on a "net commission" basis. They must be required to keep much closer tabs on their agents, check them out more thoroughly, and be punished for not reporting illegal practices.

My story is now nearly over. But it would not be complete unless I acknowledged some of the people who contributed most to the success of our effort. First, I want to thank Rick Evans, the project manager who plotted strategy and invented the data format we used with such effect. In addition, despite his management position Rick was still willing to do whatever it took, even to chasing a bathrobe-clad insurance agent through a dark apartment house hallway to serve a subpoena. I'd also like to thank Tom Pursell, who dreamed up many of the new laws and theories and did most of the front-line legal work. Tom also travelled all over the state to talk to senior citizen and insurance agent groups and, he swears, only stopped to go fishing once. Some others:

John Combs, himself a senior citizen (and now retired), who tirelessly pried information out of insurance companies and transcribed it onto endless forms. John once sat in on a suspect agent's sales pitch posing as a consumer's brother-in-law. When his concealed tape recorder (actually a state-issue dictaphone) began to buzz at the end of the tape, John convinced the suspect that the noise was a recurring problem with his pacemaker.

George Golden, who came to know off the top of his head every premium on every policy, from every company selling supplemental insurance in the State of Minnesota. George, by the way, was a victim of the "Shopping Bag Syndrome." He got so tired of seeing shopping bags full of insurance policies that he had to send his kids to the grocery store for months.

I must also acknowledge Mike Markman, former Commissioner of Insurance, who first brought the Medicare supplement problem to our attention and who drafted the 1981 Medicare Supplement Act: his investigator, Glenn Pierce, who uncovered the first overselling cases and charmed the people into cooperation: and Mike Hatch, the current Commissioner of Commerce, whose agency has become an aggressive enforcer of the insurance laws.

My final thanks are to the the members of this Subcommittee who invited me here today. Without your pioneering efforts, the abuses in the sale of Medicare supplement insurance might not have been exposed for many more years. We in Minnesota benefited greatly from your work, and I hope that I have now in some small measure returned the favor. Thank you very much.

[GS] [FILE NO. dp1:inv63] (AREA: Benson)

Insured: Mrs. B.
Date: November 2, 1983

(A) Insured	(B) Agent	(C) Company	(D) App Date	(E) Pol No	(F) Pol Date	(G) Pol Fee	(H) Prem Pd	(I) Corr Prem	(J) O/C	(K) Ch No	(L) Date Pd	(M) Amt Pd	(N) Payee	(O) A,S Q,M	(P) Exp Date	(Q) A,T L,R	(R) Typ of Pol
Mrs. B.		Homested	490301	401742	490301		25.00	25.00			490301	25.00		A			Life
Mrs. B.		Homested					50.53	50.53			520000	50.53		A			
Mrs. B.		Homested					4.80	4.80			740500	4.80		M			
Mrs. B.		Homested					50.53	50.53		2052	820323	50.53		A			
Mrs. B.		Homested					50.53	50.53		2157	830323	50.53		A	840401	A	
Mrs. B.		Woodmen	540000	1572361	540000						540000			A			Acc
Mrs. B.		Woodmen		1572361							550000			A	560000	L	
Mrs. B.	A	Woodmen	560514	1620575	560514		26.00	26.00			560514	26.00		A			Hr
Mrs. B.	A	Woodmen			590701		20.00	20.00			590701	20.00		A			
Mrs. B.	A	Woodmen			620101		25.00	25.00			620101	25.00		A			
Mrs. B.	A	Woodmen			750101		32.50	32.50			750101	32.50		A			
Mrs. B.	A	Woodmen			770101		45.50	45.50			770101	45.50		A	780101	L	

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Mrs. B.	A	Woodmen	581201	1678397	581201		22.60	22.60			581201	22.60		Q	611216	L	PHs
Mrs. B.	A	Woodmen	670220	1817032	670220		66.00	66.00			670220	66.00		A	770301	L	Hs
Mrs. B.	B	Woodmen	710513	1858969	710513		51.00	51.00			710513	51.00		A	710519	E	Hs
Mrs. B.	C	NatState	750422	78574	750422	10	300.00	277.00	23.00		750422	310.00		A			MS
Mrs. B.	C	NatState					277.00	277.00		1357	760420	277.00		A	770422	L	
Mrs. B.	D	Reliable	760514	00087304	760514	10	301.00	301.00			760514	307.00		A			MS
Mrs. B.	D	Reliable						301.00			770000			A			
Mrs. B.	D	Reliable					70.00			1600	780328	210.00	Reliable	A			
Mrs. B.	D	Reliable					231.00	301.00		1605	780426	231.00	Reliable	A			
Mrs. B.	D	Reliable					338.00	301.00		1644	781000	338.00	Reliable	A			
Mrs. B.	D	Reliable					317.80	317.80		1721	790502	317.80	Reliable	A	800514	L	
Mrs. B.	E	Medico	770223	72540	770224	15	266.00	266.00		1531	770223	635.20	F		780301	L	SNH

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Mrs. B.	E	Medico	770223	72524	770224	15	29.70	29.70		1531	770223	605.20	F		770601	L	HI
Mrs. B.	E	PersInd	770223	237121	770302	10	269.50	269.50		1531	770223	605.20	F		780302	L	MS
Mrs. B.	A	PersInd	770308	237249	770315	10	172.00	172.00		1542	770308	182.00	PersInd	A	780315	L	SNH
Mrs. B.	G	Reliable	770523	10010772	770523	10	190.00	190.00			770523	200.00		A	780523	L	NH
Mrs. B.	E	Medico	770908	86179	770908	15	44.00	44.00		1654	770907	510.00	Medico	A	781001	L	IC
Mrs. B.	C	Medico	770908	86181	770908	15	80.00	80.00		1654	770907	510.00	Medico	A	781001	L	HmR
Mrs. B.	E	Medico	770908	86186	770908	15	60.00	60.00		1654	770907	510.00	Medico	A	781001	L	C
Mrs. B.	E	Medico	770908	86178	770908	15	266.00	266.00		1654	770907	510.00	Medico	A	771018	L	SNH

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	(A) Insured	(B) Agent	(C) Company	(D) App Date	(E) Pol No	(F) Pol Date	(G) Pol Fee	(H) Prem Pd	(I) Corr Prem	(J) O/C	(K) Ch No	(L) Date Pd	(M) Amt Pd	(N) Payee	(O) A,S Q,M	(P) Exp Date	(Q) A,T L,R	(R) Typ of Pol
111	Mrs. B.	E	PersInd	771104	240002	771115	10	364.00	273.00	91.00	1667	771102	364.00	F		781115	L	SNH
113																		
114	Mrs. B.	D	Reliable	771210	10037285	771210		57.00	57.00		1585	771210	228.75	Reliable	A	781210	L	
116																		
117	Mrs. B.	D	Reliable	771210	142231	771212	10	151.75	151.75	10	1585	771210	228.75	Reliable	A	781212		
119																		
120	Mrs. B.	D	Reliable	780328	10049485	780328	10	130.00	130.00		1600	780328	210.00	Reliable	A	790328		
122																		
123	Mrs. B.	D	UnBank	780510	3851960	780510	10	320.70	320.70		1608	780510	330.70	UnBank	A	790510	L	Hs
125																		
126	Mrs. B.	H	BenefStd	780831	2500293850	780922	10	331.10	331.10			780831	341.10		A	790922	L	HsI
128																		
129	Mrs. B.	I	Reliable	781018	206531	781018		165.00	165.00		1642	781018	165.00	Reliable	A			Life
131	Mrs. B.	I	Reliable					165.00	165.00		1762	791011	355.00	Reliable	A	801018	L	
133																		
134	Mrs. B.	J	Reliable	781018	10072861	781018	10	190.00	190.00		1643	781018	200.00	Reliable	A			SN
136	Mrs. B.	J	Reliable					190.00	190.00		1762	791011	355.00	Reliable	A	801018	L	

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Mrs. B.	K	LumMan	781121	PA953151	781121	15	281.40	281.40		1680	781121	296.40	KemperI	A	791120	L	Hs
Mrs. B.	K	UnFid	781128	9392409	781130	10	572.00	572.00		1681	781128	582.00	L	A	791130	L	HsI
Mrs. B.	M	AmPat	790118	9676181	790125	10	490.00	490.00		1697	790116	640.00	L	A	800125	L	MS
Mrs. B.	M	Medico	790116	A33412	790118	15	144.00	144.00	13.00	1697	790116	640.00	L	A	790201	R	HsI
Mrs. B.	N	AmPat	790410	9676200	790416	10	344.00	269.50		1714	790410	354.00	L	S	830810	T	MS
Mrs. B.	N	Medico	790410	A41178	790410	15	60.00	60.00		1714	790410	354.00	L	A	800501	L	C
Mrs. B.	D	Reliable	790502	10093354	790502	10	120.00	120.00		1722	790502	320.25	Reliable	A	800502		
Mrs. B.	D	Reliable	790502	00145626	790502	10	180.25	180.25		1722	790502	320.25	Reliable	A	800502		

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	(A) Insured	(B) Agent	(C) Company	(D) App Date	(E) Pol No	(F) Pol Date	(G) Pol Fee	(H) Prem Pd	(I) Corr Prem	(J) O/C	(K) Ch No	(L) Date Pd	(M) Amt Pd	(N) Payee	(O) A,S Q,M	(P) Exp Date	(Q) A,T L,R	(R) Typ of Pol
163	Mrs. B.	O	Reliable	790508		790508		165.00	165.00		1725	790508	165.00	Reliable	A	790629	T	Life
166	Mrs. B.	D	Reliable	790621	10100683	790621	10	110.00	110.00		1734	790621	260.00	Reliable	A	800621		
169	Mrs. B.	D	Reliable	790621	10100684	790621	10	130.00	130.00		1734	790621	260.00	Reliable	A	800621		
172	Mrs. B.	P	PersInd	791107	0248959	791121	10	872.00	872.00		1775	791107	882.00	PersInd	A	801121	L	SM
175	Mrs. B.	P	PersInd	800128	0250302	800128	10	332.00	332.00		1794	800118	342.00	PersInd	A	810128	L	MS
178	Mrs. B.	Q	Reliable	800128		800128		165.00	165.00		1795	800128	165.00	Reliable	A	800221	R	Life
181	Mrs. B.	P	MassInd	800225	210477110	800225	15	585.00	585.00		1803	800225	600.00	L	A	810225	L	HsC
184	Mrs. B.	J	Reliable	800312	10145065	800312	10	566.04	306.04	260	1810	800312	633.04	Reliable	A	810312		
187	Mrs. B.	J	Reliable	800312	10145070	800312		57.00	57.00		1810	800312	633.04	Reliable	A	810312	L	C

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10 (A) (B) (C) (D) (E) (F) (G) (H) (I) (J) (K) (L) (M) (N) (O) (P) (Q) (R)
11 Typ
12 App Pol Pol Pol Frem Corr Ch Date Amt A,S Exp A,T of
13 Insured Agent Company Date No Date Fee Pd Prem O/C No Pd Pd Payee Q,M Date L,R Pol
14 ---
15
189
190 Mrs. B. R MassInd 800522 800522 15 447.00 1832 800522 462.00 L A 800605 R HsC
192
193 Mrs. B. UnFid 800531 8913209 800531 1.00 1.00 800531 1.00 M 800627 T HS
195
196 Mrs. B. S Reliable 800820 10173888 800820 10 376.00 376.00 1860 800820 386.00 Reliable A 810820 L
198
199 Mrs. B. E Medico 801003 A79677 801003 15 385.00 385.00 1877 801003 400.00 L A 801027 R HS
201
202 Mrs. B. T LumMan 801021 PC313106 801021 15 281.40 281.40 1887 801021 296.40 U A 811020 L HSI
204
205 Mrs. B. V LumMan 801125 PC309020 801125 15 567.00 567.00 1895 801125 582.00 U A 811125 L HS
207
208 Mrs. B. M Guarante 810108 741.25 1914 810109 741.25 W A 810119 T Hs
210
211 Mrs. B. T MutPro 810112 560537 810112 15 96.00 96.00 1915 810112 111.00 U A 820201 L C
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(A) Insured	(B) Agent	(C) Company	(D) App Date	(E) Pol No	(F) Pol Date	(G) Pol Fee	(H) Prem Pd	(I) Corr Prem	(J) O/C	(K) Ch No	(L) Date Pd	(M) Amt Pd	(N) Payee	(O) A,S Q,M	(P) Exp Date	(Q) A,T L,R	(R) Typ of Pol
Mrs. B.	X	Reliable	810217	10205187	810217	10	327.95	327.95		1928	810217	337.95	Reliable	A	820217	L	
Mrs. B.	Y	PersInd	810420	0258027	810420	10	645.00	645.90		1948	810505	655.00	PersInd	A	820420	L	S
Mrs. B.	Z	Guarante	810514			10	131.05			1954	810515	754.25	W	A			HS
Mrs. B.	Z	UnAm	810514			10	379.50			1954	810515	764.25	W	A		T	MS
Mrs. B.	Z	UnAm	810514			6	227.70			1954	810515	764.25	W	A		T	H&I
Mrs. B.	Z	UnAm	810615	3590133	810615	6	227.70	227.70		1954	810515	764.25	W	A	810817	T	H&I
Mrs. B.	Z	UnAm	810615	3590134	810801	10	379.50	379.50		1954	810515	764.25	W	A	810817	T	MS
Mrs. B.	A	UnAm	810713	1421017	810713		276.08	276.08			810713	276.08		A	820713	L	Life
Mrs. B.	AA	Guarante	810727	A672558	810810	10	131.05	131.05			810727	141.05		A	810820	T	SNH

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(A) Insured	(B) Agent	(C) Company	(D) App Date	(E) Pol No	(F) Pol Date	(G) Pol Fee	(H) Prem Pd	(I) Corr Prem	(J) O/C	(K) Ch No	(L) Date Pd	(M) Amt Pd	(N) Payee	(O) A,S Q,R	(P) Exp Date	(Q) A,T L,R	(R) Typ of Pol
Mrs. B.	AA	Guarante	810727	A672313	810807	15	159.00	159.00		1970	810727	174.00	Guarante	A	810820	T	H
Mrs. B.	BB	MassInd	810817	211084960	810817	15	684.00	684.00		1977	810826	699.00	CC	A	820817		MS
Mrs. B.	DD	MassInd	820914					684.00	684.00	2111	821012	684.00	MassInd	A	830918	A	
Mrs. B.	Y	NAEquity	811007	133840	811007	15	460.30	460.30		1991	811007	475.30	NAEquity	A			Life
Mrs. B.	Y	NAEquity						460.38			820000	460.38		A	831007	A	
Mrs. B.	S	UnBank	811104	3946282	811104		734.70	734.70		2001	811104	734.70	EE	A	821104	L	MS
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Mrs. B.	FF	Medico	820114	0718838	820114		448.50	448.50		2026	820106	680.00	Medico	A	820301	R	Life
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11																	Typ
12				App	Pol		Pol	Prem	Corr		Ch	Date	Amt		A,S	Exp	A,T	of
13 Insured	Agent	Company	Date	No	Date		Fee	Pd	Prem	O/C	No	Pd	Pd	Payee	Q,M	Date	L,R	Pol
14																		
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266 Mrs. B.	H	UnAm	820617	D142529	820617			276.08	276.08		2077	820617	724.43	HH	A	820713	T	Life
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269 Mrs. B.	H	UnAm	820617	3485636	820709	10		438.35	438.35		2077	820617	724.43	HH	A	830709	A	MS
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272 Mrs. B.	II	UnAm	820921	1426441	821006			576.00	577.24		2103	820921	576.00	UnAm	A	821027	T	Life
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275 Mrs. B.	JJ	MutPro	820922	595284	821004	15		497.00	497.00		2104	820922	512.00	MutPro	A	821004	H	MS
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278 Mrs. B.	KK	UnAm	821109	1430921	821015			577.24	577.24		2120	821109	577.24	UnAm	A	831015	A	Life
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284 Mrs. B.		MutIndem									1604	780425	367.50	MutIndem				
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291																		

KEY TO PRINTOUT COLUMNS

(A) Insured's name.

(B) Sales agent's name.

(C) Insurance Company.

(D) Date of Application. (All dates are year first, month and day.)

(E) Policy Number.

(F) Effective date of the policy.

(G) Policy fee. The policy fee is a one-time service charge for the issuance of the policy. It usually goes to the agent.

(H) Premium actually paid.

(I) Correct premium.

(J) Overcharge, (H) minus (I).

(K) Check number.

(L) Date of check.

(M) Amount paid. (May include payment for more than one policy.)

(N) Payee on the check -- usually a company, sometimes an agency or agent.

(O) Mode of premium payment -- annual, semi-annual, quarterly or monthly payments.

(P) Expiration date of the policy.

(Q) Policy status, active, terminated (i.e. cancelled by insured or some other party), lapsed (not renewed), or rejected (not issued by the company).

(R) Type of policy. MS=Medicare supplement, C=cancer, HI=hospital indemnity, HmR=home recovery, IC=intensive care, NH=nursing home, SN=skilled nursing home, HsC=hospital confinement, LI=life.

Mr. WYDEN. Gentlemen, it was my intention to just keep moving but Mr. Regula is on a tight schedule. If he would like to ask a question that will be fine.

Mr. REGULA. Thank you, Mr. Chairman, just one question.

Mr. Attorney General, you said no meaningful regulation. Were you referring to States or Federal?

Mr. HUMPHREY. I am saying at the Federal level. It is very difficult to have a meaningful regulation because of some of the acts that you have mentioned, I believe earlier in comments before the committee here, and the fact that we must keep our focus within our jurisdiction. If the industry has us divided up into 50 different jurisdictions, it is a pretty easy way of making sure that we don't have that comprehensive regulatory control.

Mr. WYDEN. Gentlemen, let's keep moving. Again, we will put your prepared remarks into the record in their entirety. If you could perhaps summarize in five minutes or so, that will leave some time for questions.

Let's go to you next, Mr. Pomeroy.

STATEMENT OF HON. EARL R. POMEROY

Mr. POMEROY. Thank you, Congressman. I will be very brief.

I am very pleased to be here to make some remarks on this matter. At the outset, I would like to say that at least our experience in the State of North Dakota is that there are certain products on the market that have merit in the Medicare supplement coverage area, and there are agents marketing those products of the highest integrity. That said, this is an area that gives us our biggest problem with respect to consumer complaints, and there are some reasons why.

As has been mentioned, the complaints seem to fall in areas that are predictable given the reimbursement mechanism for agents. The commission structure encourages overselling, encourages twisting.

Another thing that hasn't been mentioned, there is in many policies an incidental nursing home benefit, which is a very minimal benefit which pays only in the exceptional circumstances. I believe it is more in the line of illusory benefit. But yet, this particular benefit is a great marketing tool to the companies. It is very much oversold. And people buying a Medicare supplement coverage all too often believe that they have completely their nursing home insurance needs.

I think that that is another problem that needs to be looked at.

How do we address these as regulators? Well, generally, I think the experience of not just the North Dakota department, but State departments generally, are to establish consumer complaint divisions. We can get people their money back. We can prosecute agents that have lied and misrepresented the products that they are selling.

I will tell you, that it is a very difficult thing, unfortunately, to successfully prosecute the agents that are giving us the biggest problem because the witnesses are inherently feeble. For one thing, I have to evaluate whether or not I really want to—whether it is in the person's best interest to bring an 85-year-old from Williston, a

3-hour drive, to Bismarck, to hold a hearing. Those are considerations that make it difficult to prosecute the abuse.

We do our best with consumer education, both by appearing to senior citizens and public announcements, buyer's guides, the whole business. But I am afraid that we are only touching the tip of the iceberg. Certainly the market penetration ability of the insurance industry through television, direct mail, and door-to-door sales, far surpasses the number of people that we can reach through the best efforts of our departments.

I think that no matter what we do in the insurance department, to attempt to address this need—and we have, I believe, been successful for those people that contact us. Unfortunately, all too often, we are only contacted after a relative becomes involved. I just wonder how many problems are out there that we never learn of.

The concerns, no matter whether this is addressed at the Federal level, whether this is addressed at a State level, is going to be, I think, somewhat less than a complete answer to the problem so long as you have a situation where the Medicare Program only covers part of the cost that these individuals are incurring.

First of all, you have a population that is tremendously afraid of ruinous health costs. The pitch—you don't want to be a burden to your family can be a terribly technique in closing a sale regardless of whether the product is well advised for the individual or not.

Second, the complexity of the product—dovetailing under Medicare benefits—it is a tremendously complex product to market. This is our best effort to put together a North Dakota buyer's guide comparing the policies. I am not sure that ou buyer's guide makes it any more clear than anything else. In other words, looking at this, I still don't know what I am buying.

Finally, you have a marketing mechanism whereby insurance companies are not allocating, I don't think, enough resources to making sure that their agents are behaving themselves. In fact, to the contrary, because of the commission structure and incentive sales, agents are encouraged to oversell.

Here from the Bismarck Tribune, a recent article, three agents pictured and noted that they have received new cars from a Texas-based insurance company to honor their sales efforts with senior citizens. I bet those cars weren't awarded for serving in fiduciary capacity to those agents. Those cars were awarded for producing. It's selling policies and those things that provide the incentive to abuse and oversell.

I am just somewhat at a loss, Mr. Chairman and members of the committee, in terms how any means of State regulation, or Federal regulation, for that matter, is going to effectively solve this problem.

Thank you.

Mr. PEPPER. (presiding). Thank you very much, Mr. Pomeroy.

[The prepared statement of Mr. Pomeroy follows:]

PREPARED STATEMENT OF EARL R. POMEROY, COMMISSIOENR OF INSURANCE STATE OF NORTH DAKOTA

Mr. Chairman and Members of the Committee:

Thank you for the opportunity to testify on this matter.

My name is Earl Pomeroy. I am the Commissioner of Insurance for the State of North Dakota. I am presently serving as Vice Chairman of the National Association of Insurance Commissioners Task Force on Medical Supplement and Long-Term Care Insurance.

I am not testifying today formally on behalf of the NAIC, but as a state insurance regulator.

In my state, the single largest area of consumers' complaints we receive regard insurance products sold to the elderly. The most widely sold insurance product to senior citizens is Medicare Supplement insurance, also known as medigap insurance.

The complaints fall into three general areas, each of which is primarily related to the sale of the insurance policy. In our experience, it is not so much that the insurance product is faulty, as it is that there are abuses in the marketing of the product.

The largest number of Medicare Supplement complaints we receive involve the replacement of one Medicare Supplement policy with another. This practice, known as rolling the business over, is driven by the commission schedule paid to the agent. First year commissions are considerably higher than renewal commissions (paid when a policyholder renews the coverage for a subsequent year). It is not uncommon to find first year commissions to the selling agent at 60% of the premium, with an additional 20% going to the general agent.

The evil of this practice to the consumer is that Medicare Supplement policies commonly involve a six-month waiting period for pre-existing medical conditions. A consumer replacing his or her policy should continue paying on the policy in force for the first six months of the new policy to make certain there will be coverage. Consequently, the consumer pays double premiums during the six month waiting period. Often this is not fully explained to the consumer and the existing policy is dropped. In these cases, the consumer is not insured for the situation most likely to cause medical expenses--the pre-existing health condition.

A second area of trouble involves agents who sell more insurance coverage than the individual needs. All too frequently, we run into cases where the individual has been sold several policies providing overlapping, redundant benefit schedules. The cost of carrying too much insurance can be enormous. For example, we had a complaint involving an elderly woman who spent $11,000 on health insurance premiums in an 18-month period.

A third area of concern involves the practice of misrepresenting the nursing home coverage included in many Medicare Supplement policies. Often the nursing home coverage is an incidental benefit--if not illusory benefit--that pays only in exceptional circumstances. Nonetheless, consumers frequently believe they have their nursing home needs fully covered by the Medicare Supplement coverage. In essence, I believe the incidental nursing home benefits give companies and agents a marketing tool out of all proportion to its actual value to the consumer.

The conventional way our insurance department--and I believe most insurance departments--deal with this situation is to establish consumer complaint divisions where improper sales tactics or improperly denied claims can be reported.

Other regulatory responses include providing consumer education programs, distributing buyer's guide comparisons, establishing toll-free consumer hotlines and running Public Service Announcements promoting the visibility and accessibility of insurance department complaint procedures.

Based on the complaint volume in my state, I believe state insurance departments help thousands of people with Medical Supplement problems each day. I fear, however, that we are only dealing with the tip of the iceberg in what may be a far-reaching problem area for this nation's elderly.

There are limits on the ability of any regulatory scheme to successfully address this issue. First of all, any system relying on complaints only addresses problems as they occur.

Despite our efforts to encourage Medical Supplement policyholders to contact the insurance department, I believe we become aware only of a relatively small number of cases compared to the total number of policyholders with problems. Often it is only when another family member intervenes that we become informed of a problem area.

The consumer education efforts undertaken by insurance departments represent a good effort to inform the public. I worry, however, about the relatively small percentage we talk to, compared to the market penetration of television advertising, direct mail, or those contacted individually by agents.

I'm not certain additional regulations will solve the problem. Recently a subcommittee of the NAIC Medicare Supplement Task Force I serve on explored whether variations in state regulations appreciably effected market experience. Our study was not exhaustive, but did not point out any particular regulatory framework as being more effective than another.

By my view the NAIC Task Force study did not give this area a clean bill of health. It simply did not substantiate that any particular regulatory framework dictated whether or not a state would experience problems in these areas.

It seems to me several factors make it inevitable that senior citizens will have problems purchasing the insurance they need to cover the medical costs not covered by the present medicare program.

The policies are inherently complex, providing an infinite variety of coverages which make direct costs comparisons between policies very difficult.

Senior citizens, as a group, are particularly sensitive to the threat of ruinous medical bills. They are thus particularly susceptible to high pressure sales tactics that prey on this fear. Suggestions that an individual may present a financial burden to their family can effectively close a number of policy sales.

The framework for marketing Medical Supplement insurance will create abuses in the sale of this product. Agents are paid on a lucrative commission basis. The more they sell, the more they earn. Often the agency force is only minimally supervised by their insurance company. In addition, sales incentives, such as free automobiles, push agents to oversell the coverage.

I wish to emphasize that there are a great number of high quality Medicare Supplement policies on the market being sold by agents of the highest professional integrity.

At least in my state, however, there are serious problems in the marketing of Medicare Supplement insurance. As a consequence, there is widespread confusion and concern among senior citizens regarding the insurance required to cover the medical expenses incurred over and above those covered by the medicare program.

Mr. PEPPER. Now the Honorable Peter Hiam, commissioner of insurance of Massachusetts.

STATEMENT OF HON. PETER HIAM

Mr. HIAM. Mr. Chairman, thank you for the opportunity that the committee has given me to appear today for you.

My name is Peter Hiam. I am the commissioner of insurance, the Commonwealth of Massachusetts.

We have been fortunate in Massachusetts not to have had the type of widespread abuses in the advertisement and sale of medigap insurance that have occurred in many other States. I attribute our success to three factors. First, our Medigap regulation in 1980 is among the toughest in the country. Second, Blue Cross and Blue Shield dominate the medigap market in Massachusetts, and they are subject to close regulatory scrutiny by the Division of Insurance. Third, we have taken aggressive enforcement action where medigap sales or marketing abused have been identified.

I would like to describe each of these factors in a little more detail because I think they provide insight into effective State regulatory strategies for dealing with abuses in the medigap market.

In Massachusetts, medigap regulation, adopted in 1980, covers all individual policies sold in the State. It is in a number of respects, more stringent than the voluntary Federal guidelines. The most significant difference is that unlike the Federal guidelines, we have adopted a mandatory standardized benefit approach rather than a minimum benefit approach to medigap policies. Our regulation specifies three levels of medigap coverage. Any medigap policy sold in Massachusetts must comply with one of these three benefit options and they may not be modified in any way. The benefits in even the lowest option are more comprehensive than the Federal standards.

The standardization of medigap benefits in Massachusetts has been an important factor in ensuring reasonably comprehensive medigap coverage and in reducing consumer confusion. It enables consumers to more easily compare medigap policies and reduces the opportunity for unscrupulous sellers to misrepresent what they are selling. Our regulation also requires that a detailed policy summary be provided to the consumer by the insurer at the time of application for medigap coverage. The exact form of this summary is specified in the regulation, and it includes a side-by-side comparison of the benefits provided by parts A and B of Medicare and by each of the three types of medigap coverage. I might note that it also must include the expected loss ratio of the policy. This helps the potential policyholder to determine which coverage option is best suited to his or her needs.

Another significant difference between the Massachusetts regulation and the Federal guidelines is that the Massachusetts regulation does not allow medigap insurers to impose waiting periods or exclusions for preexisting medical conditions. We believe this requirement is more consistent with the Medicare program itself which does not require such conditions and restrictions. In addition, the prohibition has reduced the opportunity for marketing abuses such as twisting in which unscrupulous sellers attempt to

increase their commissions by selling replacement policies to consumers each year, thereby subjecting policyholders to new waiting periods and exclusions for preexisting conditions.

The second factor which has limited medigap abuses in Massachusetts is the special role of Blue Cross and Blue Shield. The Blues are the dominant health insurers in the State with an overall market penetration of over 60 percent. Our best estimate is that approximately 80 percent of the people in Massachusetts who have medigap policies are covered by the Blues.

The Blues nongroup programs are heavily regulated by the Division of Insurance. They are required to hold an annual medigap open enrollment period of at least 2 months, during which any resident of Massachusetts is able to enroll in any of the three medigap plans offered by the companies. Premium surcharges based on age are statutorily prohibited. Eighty-five percent of the Blues medigap members have the so-called Medex 3 Plan, and that is by far the most popular plan. And that is the most comprehensive coverage offered by the companies. I might note that the Medex 3 Plan was rated as the top medigap plan in the country by the Consumer Reports study and issued in 1984.

One of the most significant forms of regulatory oversight which the Blues are subject to is that any nongroup rate increase, that includes Medex, must receive the prior approval of the division of insurance after a public hearing. These hearings are lengthy and contentious. Last year's hearing took 19 days. The Blues must not only demonstrate that their proposed rates are reasonable and actuarily justified, but under under the terms of the law advocated by Governor Dukakis in 1984, they must also show that they have effective utilization review and cost control measures in place.

This cost containment requirement has been impetus for a number of changes which have directly benefited medigap policyholders. I will mention only one. We have been very much concerned about the rapid rise in the drug benefit under the Blues medigap plans. In the 1984 rate hearing I disapproved their proposal because they didn't have adequate cost containment proposals for the drug benefit. They came back in with a new drug benefit program which was then approved, and that has a maximum allowable charge schedule for prescription drugs purchased by Medex subscribers.

Massachusetts is also the first State in the country to pass legislation that prohibits physicians from billing Medicare patients in excess for the fees which the Medicare Program determines to be reasonable. Blue Cross and Blue Shield medigap members have had this protection since 1984. It was extended to all Medicare beneficiaries in April of this year.

Now, as to enforcement action, one indication of the success of our regulatory approach in Massachusetts is the small number of complaints which the division receives about medigap abuses. In 1985, fewer than 100 of the 8,000 complaints received by the division, and almost none of the 65,000 telephone inquiries we handled, related to medigap coverage.

The great majority of our medigap complaints—and remember, there were fewer than 100 were against Blue Cross and Blue

Shield, and most of those complaints had to do with delays in payment.

Although we do not receive many complaints, we have taken aggressive enforcement action when abuses have been identified. In recent years, as a result of the division's investigation in the medigap abuses, we have suspended the licenses of 2 companies, revoked the licenses of 2 corporate agencies, and 10 individual agents or brokers, imposed administrative fines for approximately $100,000, and obtained over $1 million in refunds for defrauded consumers.

Our efforts have led to approximately to 15 criminal convictions.

In addition, in 1984, we reached agreement with one national insurer to stop the sale of its mass merchandise policies in Massachusetts, after our enforcement and legal sections determined that the marketing practice of the company were misleading and deceptive.

The Division is currently conducting an investigation into the activities of the sales forces for three forces domiciled outside of Massachusetts. Agents for these companies are allegedly engaged in a variety of abusive practices in selling medigap coverage, including the use of the Government-look sales tactic in which marketing literature and membership cards resemble Medicare material.

Strong enforcement action is a critical component of any strategy to eliminate abuses in the medigap market.

Although we have seen less widespread Medigap abuses than in many other States, we do still have significant problems. I think enforcement activities would demonstrate that, particularly with mass merchandise policies.

And I would like to note that we have seen a marked increase in the visibility of mass merchandise policies in Massachusetts the last few years. I believe this increase is directly related to the significant cutbacks in the Medicare Program, particularly the increases, the deductibles, and copayments. Cost shifting by the Federal Government has increased the anxiety of Medicare beneficiaries about their ability to meet medical expenses not covered by Medicare. You have heard from the first task force on that this morning. And that has fostered the environment in which medigap abuses can flourish. The Federal Government has an obligation to cope with the problems which have been caused by these cutbacks.

I also believe that there are a number of actions which the Federal Government can take to reduce abuses and the sale and marketing of mass merchandise medigap policies. I have two specific recommendations.

The first is the adoption of a minimum group statute by the Federal Government. Most States have limited jurisdiction over the terms of group health insurance. The presumption underlying these limits is that a group will act to protect the interest of its members so that little regulation is needed. However, many of the worst medigap policies are sold through fictitious groups which have been created only for the purchase of insurance and the avoidance of State insurance regulation.

These policies are issued in States which have very lenient rules about what constitutes a group. We have seen policies where the group is quite literally two elders covered under a group policy held by a bank, for example. In such cases, the group is not acting

to protect the interests of its members and it is only fronting for the insurance company. And the way that AARP was alleged to have been a schill for Colonial Penn—and I am glad to say that situation has totally turned around.

However, because such an arrangement can arguably constitute a group under the laws of certain States, it is exempt from strict scrutiny. It is difficult, if not impossible, for other States to regulate such policies.

One way in which the Federal Government could intervene to correct this problem is by adopting a minimum group statute designed to prohibit fictitious groups. The statute would need to be no more complex than the standardized definition that a group must have a purpose other than the purchase of insurance. And although the Federal Government could certainly go beyond this point in its definitions if it chose to do so. I would suggest that the Federal Government could defer to the States which had stronger group definitions.

I believe there is also a need for a national unfair and deceptive practices standard with significant monetary penalties for violations, such as the treble damages penalties under RICO and Federal antitrust law.

Again, this standard could supplement rather than supplanting State action. We happen to have a very strong unfair and deceptive practices standard in Massachusetts, but not all States do.

Finally, I would like to express my concern about the need for strong State and Federal regulatory action, another elderly health care insurance market, but one that is closely connected, that of long-term care insurance.

As you know, there is a growing interest and development of private long-term care insurance products. In 1985, the Massachusetts Division of Insurance commissioned a survey of long-term insurance. Among other things, that survey found that existing policies varied enormously in the extent and duration of benefits. Their premiums and benefits did not appear to be systematically correlated, and the policy language was not standardized and was highly susceptible to policyholder misunderstanding.

On the basis of that survey, the division is currently developing a specific long-term care insurance regulation. Now, this is obviously closely related to Medicare because so many people that are covered by Medicare and get medigap policies think that it covers long-term care insurance.

I am very concerned if the Federal Government doesn't take action, as people do move to get long-term care coverage, they are going to be subjected to the same kinds of abuses, unreadable language, and coverage in terms of dollars per day and that type of thing, which is simply not going to be useful for them in terms of the financial catastrophe of long-term care.

Now, long-term care insurance is a new type of coverage. It raises a variety of difficult regulatory issues that are outside the scope of this morning's hearing, I realize. But I think that it is vital that we learn from our experience from Medicare supplemental coverage in our approach to private long-term care insurance. And if we can apply the lessons we have learned in the medigap market, we may be able to prevent a similar set of problems—sales

abuses, low value products, and consumer confusion. All under the label of long-term care insurance.

As you know, there have been a number of proposals to expand the scope of the Medicare Program to include long-term care. At least conceptually, I believe such a unified approach has merit for several reasons.

First, cost containment would be easier if Medicare controlled the majority of the health care cost of the elderly. A unified approach would also encourage Medicare to think systematically about the global health care needs of the elderly instead of maintaining a narrow focus on acute care services.

Finally, a more comprehensive and comprehensible system of health insurance for the elderly would reduce the opportunities for the type of insurance marketing abuses which have occurred under the current fragmented and complex Medicare system.

Thank you for the opportunity to appear here this afternoon.

[The prepared statement of Mr. Hiam follows:]

PREPARED STATEMENT OF PETER HIAM, MASSACHUSETTS COMMISSIONER OF INSURANCE

Good morning. My name is Peter Hiam. I am the Commissioner of Insurance for the Commonwealth of Massachusetts. Thank you for the opportunity to appear before you today to testify on this important issue.

We have been fortunate in Massachusetts not to have had the type of widespread abuses in the advertisement and sale of medigap insurance that have occurred in many other states. I attribute our success to three factors. First, our medigap regulation, adopted in 1980, is among the toughest in the country. Second, Blue Cross and Blue Shield dominate the medigap market in Massachusetts, and are subject to close regulatory scrutiny by the Division of Insurance. Third, we have taken aggressive enforcement action where medigap marketing or sales abuses have been identified.

I would like to describe each of these factors in a little more detail because I believe they provide insight into effective state regulatory strategies for dealing with abuses in the medigap market. I will then discuss several problems which we have encountered in attempting to regulate mass-merchandised medigap policies, and offer several suggestions for federal action to help states deal with these problems.

Massachusetts Medigap Regulation

The Massachusetts medigap regulation, adopted in 1980, covers all individual policies sold in the state. It is, in a number of respects, more stringent than the voluntary federal guidelines. The most significant difference is that unlike the federal guidelines, we have adopted a mandatory, standardized benefit approach rather than a minimum benefit approach to medigap policies. Our regulation specifies three levels of medigap coverage; any medigap policy sold in Massachusetts must comply with one of these benefit options and may not be modified in any way. The benefits in even the lowest option are more comprehensive than the federal standards. For example, each option requires full coverage for the 91st to 365th day in a benefit period; two of the three options require prescription drug coverage.

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The standardization of medigap benefits in Massachusetts has been an important factor in ensuring reasonably comprehensive medigap coverage and in reducing consumer confusion. It enables consumers to more easily compare medigap policies and reduces the opportunity for unscrupulous sellers to misrepresent what they are selling. Our regulation also requires that a detailed policy summary be provided to a consumer by the insurer at the time of application for medigap coverage. The exact form of this summary is specified in the regulation, and includes a side-by-side comparison of the benefits provided by Parts A and B of Medicare and by each of the three types of medigap coverage. It must also include the expected loss ratio on the policy. This helps a potential policyholder to determine which coverage option is best suited to her or his needs.

The Division has been willing to modify the mandatory benefit requirements when such a change benefits medigap policyholders. For example, in 1984 we changed the mandated prescription drug benefit to provide 100 percent coverage for generic drugs; coverage for brand name drugs remained at 80 percent. The intent of this change was to contain the increase in medigap premiums by creating a strong financial incentive for the substitution of lower-cost generic drugs.

Another significant difference between the Massachusetts regulation and the federal guidelines is that the Massachusetts regulation does not allow medigap insurers to impose waiting periods or exclusions for preexisting medical conditions. We believe this requirement is more consistent with the Medicare program itself, which does not impose such restrictions. In addition, the prohibition has reduced the opportunity for marketing abuses such as "twisting", in which unscrupulous sellers attempt to increase their commissions by selling replacement policies to consumers each year, thereby subjecting policyholders to new waiting periods and exclusions for preexisting conditions.

Special Role of Blue Cross and Blue Shield

The second factor which has limited medigap abuses in Massachusetts is the special role of Blue Cross and Blue Shield. The Blues are the dominant health insurers in the state, with an overall market penetration of over 60 percent.

They have over 450,000 medigap members, two-thirds of whom are individual, or nongroup, subscribers. Almost 60 percent of Medicare beneficiaries in Massachusetts have medigap insurance through the Blues; although there are no hard data available on the Blues' share of the medigap market, our best estimate is that approximately 80 percent of the people in Massachusetts who have medigap policies are covered by the Blues.

The Blues' nongroup programs are heavily regulated by the Division of Insurance. They are required to hold an annual medigap open enrollment period of at least two months duration, during which any resident of Massachusetts is able to enroll in any of the three medigap plans offered by the companies. Premium surcharges based on age are statutorily prohibited. 85 percent of the Blues' medigap members have the so-called "Medex 3" plan, which is the most comprehensive coverage offered by the companies. (Medex 3 was rated the top medigap plan in the country among the policies analyzed by Consumer Reports in a 1984 study.)

One of the most significant forms of regulatory oversight to which the Blues are subject is that any nongroup rate increase must receive the prior approval of the Division of Insurance after a public hearing. These hearings are lengthy and contentious; last year's Medex hearing lasted nineteen days. The Blues must not only demonstrate that their proposed rates are reasonable and actuarially justified, but, under the terms of a law advocated by Governor Dukakis in 1984, they must also show that they have effective utilization review and cost containment programs for their medigap members.

This cost containment requirement has been the impetus for a number of changes which have directly benefited medigap policyholders. For example, we have been concerned for a number of years about the rapid rise in the cost of the drug benefit in the Blues' medigap plans, and in the 1984 Medex rate hearing, we strongly criticized the proposed rates because the Blues had not demonstrated that they had taken effective action to moderate the increase in drug costs. In last year's hearing, the Blues proposed, and we approved, a new drug benefit which established a maximum allowable charge schedule for prescription drugs purchased by Medex subscribers. Medex members may only receive drug benefits for prescriptions purchased at pharmacies which have signed a participating agreement with the Blues; participating pharmacies agree to

accept the charge established by the Blues as payment in full. This program has produced real savings for Medex members.

Massachusetts is also the first state in the country to pass legislation that prohibits physicians from billing Medicare patients in excess of the fees which the Medicare program determines to be reasonable. Blue Cross and Blue Shield medigap members have had this protection since 1984, and it was extended to all Medicare beneficiaries in April of this year. The constitutionality of this law, which makes physician licensure dependent upon accepting Medicare approved charges as payment in full, was recently upheld by the federal district court. This law, which applies to all Medicare beneficiaries whether or not they have medigap coverage, provides significant protection for the elderly in Massachusetts, and similar legislation is being considered in a number of other states.

Enforcement Action

One indication of the success of our regulatory approach in Massachusetts is the small number of complaints which the Division receives about medigap abuses. In 1985, fewer than one hundred of the eight thousand complaints received by the Division and almost none of the 65,000 telephone inquiries we handled, related to medigap coverage. The great majority of our medigap complaints were against Blue Cross and Blue Shield; most of these complaints had to do with delays in payment.

Although we do not receive many complaints, we have taken aggressive enforcement action when abuses have been identified. In recent years, as a result of the Division's investigation into medigap abuses, we have suspended the licenses of two companies, revoked the licenses of two corporate agencies and ten individual agents or brokers, imposed administrative fines of approximately $100,000, and obtained over $1 million in refunds for defrauded consumers. Our efforts have led to approximately fifteen criminal convictions. In addition, in 1984 we reached agreement with one national insurer to stop the sale of its mass merchandised policies in Massachusetts after our enforcement and legal sections determined that the marketing practices of the company were misleading and deceptive. The Division is currently conducting an investigation into the activities of the sales

forces for three companies domiciled outside of Massachusetts. Agents for these companies are allegedly engaged in a variety of abusive practices in selling medigap coverage, including the use of "the government look" sales tactic, in which marketing literature and membership cards resemble Medicare material.

Strong enforcement action is a critical component of any strategy to eliminate abuses in the medigap market.

Need for Federal Action

Although we have seen less widespread medigap abuses than many other states, we do still have significant problems, particularly with mass-merchandised policies. I would like to note that we have seen a marked increase in the visibility of mass merchandised policies in Massachusetts in the last few years. I believe this increase is directly related to the significant cutbacks in the Medicare program, particularly the increases in the deductibles and copayments. Cost-shifting by the federal government has increased the anxiety of Medicare beneficiaries about their ability to meet medical expenses not covered by Medicare, and has fostered an environment in which medigap abuses can flourish. The federal government has an obligation to cope with the problems which have been caused by these cutbacks.

I believe that there are a number of actions which the federal government can take to reduce abuses in the sale and marketing of mass-merchandised medigap policies. I would like to offer two specific recommendations.

The first is the adoption of a minimum group statute by the federal government. Most states have limited jurisdiction over the terms of group health insurance. The presumption underlying these limits is that a group will act to protect the interests of its members so that little regulation is needed. However, many of the worst medigap policies are sold through fictitious groups which have been created only for the purchase of insurance and the avoidance of state insurance regulation. These policies are issued in states which have very lenient rules about what constitutes a group; we have seen policies where the group is quite literally two elders, covered under a group policy held by a bank, for example. In such cases, the group is not acting to protect the interests of its members, and is only fronting for the insurance company, in the way that

AARP was alleged to have been a shill for Colonial Penn. However, because such an arrangement can arguably constitute a group under the laws of certain states, it is exempt from strict scrutiny. It is difficult, if not impossible, for other states to regulate such policies.

One way in which the federal government could intervene to correct this problem is by adopting a minimum group statute designed to prohibit fictitious groups. The statute would need be no more complex than a standardized definition that a group must have a purpose other than the purchase of insurance, although the federal government could certainly go beyond this simple definition and specify more precisely what constitutes a permissable group. States would be free to adopt group definitions which were more restrictive than the federal standard. This approach is similar to that taken by the federal government in a number of other areas. For example, Regulation Z, the Federal Truth in Lending regulation, sets minimum federal standards for the disclosures which creditors must make to consumers. A state can be exempted from the application of these standards if it has in place a standard that is at least as strong as the minimum standard established by the federal government.

I believe there is also a need for a national unfair and deceptive practices standard, with significant monetary penalties for violations (such as the treble damages penalty under RICO and federal antitrust law). Again, this standard could supplement and not supplant state action. States would be free to adopt unfair and deceptive practices regulation that was more restrictive than the federal standards. Primary enforcement would remain at the state level, with provisions for federal action only when state remedies are exhausted or when no state action has been taken within a specified period of time. This approach would be similar to that currently employed by the Federal Equal Employment Opportunity Commission. I believe such a national standard could make a significant difference in reducing medigap marketing and sales abuses, particularly in the mass merchandised policy area.

Conclusion

Finally, I would like to express my concern about the need for strong state and federal regulatory action in another elderly health insurance market, that of long-term care

insurance. As you know, there is growing interest in the development of private long-term care insurance products. In 1985, the Massachusetts Division of Insurance commissioned a survey of long-term insurance; among other things, that survey found that existing policies varied enormously in the extent and duration of benefits, that premiums and benefits did not appear to be systematically correlated, and that policy language was not standardized and was highly susceptible to policyholder misunderstanding. On the basis of that survey, the Division is currently developing a specific long-term care insurance regulation.

Long-term care insurance is a new type of coverage, and it raises a variety of difficult regulatory issues that are outside the scope of this morning's hearing. However, I think that it is critical that regulators at the state and federal levels learn from our experience with Medicare supplemental coverage in our approach to private long-term care insurance. If we can apply the lessons we have learned in the medigap market, we may be able to prevent a similar set of problems--sales abuses, low value products and consumer confusion--under private long-term care insurance.

As you know, there have been a number of proposals to expand the scope of the Medicare program to include long-term care. At least conceptually, I believe such a unified approach has merit for several reasons. First, cost containment would be easier if Medicare controlled the majority of the health care costs of the elderly. A unified approach would also encourage Medicare to think systemically about the global health care needs of the elderly instead of maintaining a narrow focus on acute care services. Finally, a more comprehensive and comprehensible system of health insurance for the elderly would reduce the opportunities for the types of insurance marketing abuses which have occurred under the current fragmented and complex Medicare system.

Thank you for the opportunity to appear before you this morning.

Mr. PEPPER. Thank you very much, Mr. Hiam. You have impressed all of us with the excellence of your program in Massachusetts. I would commend it certainly to my State and it might be worthy of consideration by all the other States for its excellence. We are going to consider aspects of your program as possible subjects of Federal legislation as well.

Mr. HIAM. Thank you, Mr. Chairman.

Mr. PEPPER. The last witness on this excellent panel is Mr. Donald Reilly of the Leadership Council of Aging Organizations of Washington, DC. Mr. Reilly.

STATEMENT OF DONALD F. REILLY

Mr. REILLY. Mr. Chairman, I am Donald Reilly, senior vice president of The National Council on the Aging. The Leadership Council of Aging Organizations is a coalition of 30 national groups, including The National Council on the Aging, which represent or serve the aged. I am making this statement for Cyril Brickfield, Chairman of the Leadership Council.

I will submit my complete statement for the record.

Mr. PEPPER. Without objection, it will be received. Thank you very much.

Mr. REILLY. We are concerned with the well-being of the Nation's elderly and the fact that the progress against medigap abuses has been so limited to date.

As the testimony of the witnesses who have preceded me has so graphically illustrated, the section 507 legislation has not been successful overall, although some individual States have done a good job. Therefore, section 507 urgently needs review and strengthening. We also need from the administration a commitment to aggressive and consistent enforcement.

Our member organizations continue to report a stream of complaints about abuse in medigap marketing and inadequate policy coverage. The Leadership Council supports your goal of more effective law, public education, and effective regulatory enforcement across the Nation to resolve these problems.

It is clear that this is a National and a Federal Government challenge because this industry is a creature of the national Medicare Program. It exists only because of the limitations and shortcomings of the Medicare legislation. Mr. Chairman, as you know, these limitations on Medicare are producing acute pressures on the resources of older citizens, their families, and their communities.

The failures of medigap insurance that this hearing is disclosing correspond directly to the flaws in the Medicare Program. We believe that no amount of regulation of the private health insurance industry can equitably provide protection for older persons. They are now spending out-of-pocket an average of more than 16 percent of their incomes for health needs.

We join with you in demanding ethical conduct by all members of the insurance industry and concrete actions by the insurance industry itself, State insurance departments, the Congress, and the national administration, to assure that the bad policies and the bad agents are driven out of circulation.

We also assert with you that reform of the Medicare Program itself may be the most efficient way of providing full financial coverage for all part A and part B Medicare services. We know that such full catastrophic coverage is within the practical means of this society and the American economy.

There is a present need for further reform and regulation of the medigap insurance industry. However, we must also recognize that the medigap industry represents another costly layer of expensive insurance to compensate for failures to correct design flaws in our national health care system.

The real answer in the long term is a national health care program. However, none of this is intended to divert our attention from the present Medicare situation.

Medicare coverage gaps have generated a multibillion dollar parallel insurance system on which 80 percent of Medicare users depend. These medigap policyholders seek reasonable protection from mounting deductibles, copayments, bills from doctors who callously refuse Medicare fee assignment, and such uncovered services as prescription drugs, hearing aids, and dentistry.

We suggest a number of steps. First, genuine administration commitment to medigap reform. The Leadership Council is appalled that the Department of Health and Human Services has not cooperated by testifying at this hearing.

Section 507, with its requirements for administering the voluntary Medigap Emblem Program showing that policies authorized to use the emblem have met minimum standards, is Federal law. The public must be informed of the existence and administration of that law.

The failure of the Department of Health and Human Services to report to the Congress on the effectiveness of State regulatory approaches to curbing sales abuse and the adequacy of Federal criminal penalties for such abuses, to assuring clear public information, to promote policies that provide genuine economic benefits and other reforms is not excusable.

We urge Secretary Bowen to provide these reports and the reason for delays over the past 4 years to the Congress. Without them, the public and the Congress cannot have informed opinions on the degree of reform achieved within the industry and what further actions are required.

We also call for a review and recommendations by the Federal Trade Commission which has, regrettably, also declined to testify here today. The abuses in selling Medigap insurance nationally by TV pitchmen, often well-known actors who convey a false image of trust, are clearly an area which calls for action by the Federal Trade Commission.

The Congress should repeal any provisions which limit the FTC's authority to monitor the insurance industry.

Second, we also need renewed State commitment to firm regulation. We urge that the National Association of Insurance Commissioners review the evidence of continued waste and abuse which you are introducing today and pledge far more aggressive leadership and enforcement of statutory and voluntary standards of marketing conduct and policy protections.

Third, we also ask for better public education on what Medicare actually covers. On behalf of the Leadership Council, I pledge renewed efforts by our member organizations to clarify for the public the benefits and limitations of Medicare and Medigap insurance. However, the efforts of private organizations such as ours cannot, and should not, be a substitute for the vast resources available to the Federal Government for public information and education in an area which has been created by Federal policy.

We call upon the Department of Health and Human Services to mount a public education program on the benefits and limitations of Medicare and on the minimum statutory standards for Medigap policies. Surely, this second largest Federal domestic program deserves a public information effort on a par with Defense Department recruitment ads on television and radio and in the print media.

We believe that the enormous and successful media efforts of the Internal Revenue Service in promoting compliance with tax laws could also serve as a model.

At the same time, we assert that media campaigns and clearer explanatory booklets on Medicare and supplementary insurance policies are not substitutes for firm and consistent regulation of the industry together with high standards of commercial efforts.

Mr. Chairman, the Leadership Council of Aging Organizations compliments you on the timeliness of this hearing. Our member organizations stand ready to continue to work with you toward the complete elimination of abuse in the Medigap industry.

Thank you.

[The prepared statement of Mr. Reilly follows:]

PREPARED STATEMENT OF DONALD F. REILLY, SENIOR VICE PRESIDENT, THE NATIONAL COUNCIL ON THE AGING, ON BEHALF OF THE LEADERSHIP COUNCIL ON AGING ORGANIZATION

Mr. Chairman, I am Donald F. Reilly, Senior Vice President of The National Council on the Aging. Today, I am representing the Leadership Council of Aging Organizations. I am making a statement for Cyril Brickfield, our Chairman, who is unable to attend this hearing.

The Leadership Council of Aging Organizations, LCAO, is a coalition of 30 national groups, including The National Council on the Aging, which represent or serve the aged. Attached to this statement is a list of member organizations. LCAO is concerned with the well-being of the nation's elderly, and therefore the effect of Federal policy on individual elderly people and those who endeavor to meet their health, financial and social needs. We are pleased to present our views on Medigap insurance because the continuing abuse in this area remains one of our major concerns together with the limited progress against these Medigap abuses.

Mr. Chairman, on behalf of the Leadership Council, first allow me to salute you and the members and staff of this Committee for your long-term, persistent and powerful role in forging meaningful protection for vulnerable older citizens. Keep at it.

Your pioneering hearings in 1978 first brought to national attention scandalous conduct within the health insurance industry which victimized thousands of older persons in the sale of fradulent medigap policies. Your hearings and reports, in concert with the work of the Senate Special Committee on Aging and with the active support of the member organizations of the Leadership Council, led to the passage in 1980 of the first Federal-level regulation of the medigap industry. Section 507 of the Social Security Disability Amendments of 1980, has helped provide a framework for progress on Medicare supplemental insurance reform. Some progressive states have used it as basis for their regulation. Some sectors of the health insurance industry have used it to develop better medigap coverage.

We of the Leadership Council know that your personal efforts in this area have resulted in the saving of billions of dollars of older citizens' assets no longer wasted on deceptive and insufficient medigap policies.

As the testimony of the witnesses who have preceded me has so graphically illustrated, the Section 507 legislation has not been successful overall, though some individual states have done a good job. Section 507 urgently needs review and strengthening. We also need from the Administration a commitment to aggressive and consistent enforcement. Our member organizations continue to report a stream of complaints about abuse in medigap marketing and inadequate policy coverage.

The Leadership Council supports your goal of more effective law, public education and effective regulatory enforcement across the nation to resolve these problems. It is clear that this is a national and Federal governmental challenge because this industry is a creature of the national Medicare program. It exists only because of the limitations and shortcomings of the Medicare program. Mr. Chairman, as you know, these limitations on Medicare are producing acute pressures on the resources of older citizens, their families and their communities.

Several months ago, Jack Ossofsky, my colleague at The National Council on the Aging, testified, for the Leadership Council before this body on the growing Medicare catastrophic insurance crisis. At that hearing he noted that,

> "In spite of the existence of Medicare, Medicaid and private insurance, easing the elderly's burden for out-of-pocket medical and related expenses is an increasingly difficult problem. The cost of services not covered by Medicare, and the program's mandated cost-sharing levels, for example, have long been a concern to us. Another serious concern is the difficulties which elderly people and their families face in trying to obtain and pay for long-term and chronic care services, particularly those that are community based.
>
> "The LCAO and its member groups have testified before Congress many times about the high cost of nursing home and chronic care, prescription drugs and eye care, and the level of deductibles, co-payments and excessive fees of physicians who do not accept assignment. We have expressed alarm at the fact that the proportion of income the elderly now spend on health care nearly equals that of pre-Medicare days."

Mr. Ossofsky, at that same hearing, went on to note that:

> "We have told Congress of our concern that Medicare

and private insurance are of little help to Alzheimer's Disease victims or their families. We have reported that Medicaid does not help all low-income aged. Nearly six million people over the age of 65 live in or close to poverty. Only three-and-one-half million are Medicaid recipients. Many of them become eligible only by first impoverishing themselves, usually by paying for nursing home care."

Mr. Chairman, the failures of medigap insurance that this hearing is disclosing correspond directly to these flaws in the Medicare program. We believe that no amount of regulation of the private health insurance industry can equitably provide protection for older persons who are now spending, out-of-pocket, an average of more than 16% of their incomes for health needs.

We join with you in demanding ethical conduct by **all** members of the insurance industry and concrete actions by the industry, state insurance departments, the Congress and the national Administration to assure that the bad policies and the bad agents are driven out of circulation.

We also assert with you that reform of the Medicare program itself may be the most efficient way of providing full financial coverage for all Part A and Part B Medicare services. We know that such full catastrophic coverage is within the practical means of this society and the American economy.

There is a present need for further reform and regulation of the medigap insurance industry. However, we must also recognize that the medigap industry represents another costly layer of expensive insurance to compensate for failure to correct design flaws in our national health care system. The real answer is a national health care program for Americans of all ages.

However, we need to deal with the present Medicare situation. Medicare coverage gaps have generated a multi-billion dollar parallel insurance system on which 80% of Medicare users depend. Those medigap policyholders seek reasonable protection from mounting deductibles, co-payments, bills from doctors who callously refuse Medicare fee assignment, and such uncovered services as prescription drugs, hearing aids and dentistry.

We suggest a number of steps:

1. **A genuine Administration commitment to medigap reform.** The Leadership Council is appalled that the Department of Health and Human Services has not cooperated with you by testifying at this hearing. Section 507, with its require-

ments for administering the voluntary medigap emblem program, showing that policies authorized to use the emblem have met minimum standards, is Federal law and the public must be informed of the existence and administration of that law. The failure of the Department of Health and Human Services to report to the Congress on the effectiveness of state regulatory approaches to curbing sales abuse, to assess the adequacy of Federal criminal penalties for such abuses, to assure clear public information, and to promote policies that provide genuine economic benefits is not excusable.

We urge Secretary Bowen to provide those reports to the Congress and the reasons for their delay over the past four years. Without them, the public and the Congress cannot have informed opinions on the degree of reform achieved within the industry and what further actions are required.

We also call for a review and recommendations on this issue by the Federal Trade Commission which has, regrettably, also declined to testify here today. The abuses in the national selling of medigap insurance by TV pitchmen, often well known actors who convey an image of trust, are clearly an area which calls for action by the Federal Trade Commission. The Congress should repeal any provisions which limit the Federal Trade Commission's authority to monitor and evaluate the insurance industry.

2. **Renewed state commitment to firm regulation.** We urge that the National Association of Insurance Commissioners review the evidence of continued waste and abuse which you are introducing today and pledge far more aggressive leadership and enforcement of statutory and voluntary standards of marketing conduct and policy protections.

3. **Better public education on what Medicare actually covers.** On behalf of the Leadership Council, I pledge renewed efforts by our member organizations to clarify for the public the benefits and limitations of Medicare and medigap insurance. However, the efforts of private organizations cannot, and should not, be a substitute for the vast resources available to the Federal government for

public information and education in an area which has been created by Federal policy.

We call upon the Department of Health and Human Services to mount a public education program on the benefits and limitations of Medicare and on the minimum statutory standards for medigap policies. Surely this second largest Federal domestic program deserves a public information effort on a par with Defense Department recruitment ads on television and radio and in the print media. We believe that the enormous and successful media efforts of the Internal Revenue Service in promoting compliance with tax laws could also serve as a model.

At the same time, we assert that media campaigns and clearer explanatory booklets on Medicare and supplementary insurance policies are not substitutes for firm and consistent regulation of the industry together with high standards of commercial ethics.

Mr. Chairman, the Leadership Council of Aging Organizations compliments you on the timeliness of this hearing. Our member organizations stand ready to continue to work with you toward the complete elimination of abuse in the medigap industry.

Thank you.

LEADERSHIP COUNCIL OF AGING ORGANIZATIONS

American Association for International Aging

American Association of Homes for the Aging

American Association of Retired Persons

American Society on Aging

Asociacion Nacional Pro Personas Mayores

Association for Gerontology in Higher Education

Catholic Golden Age

Concerned Seniors for Better Government

The Gerontological Society of America

Gray Panthers

National Association of Area Agencies on Aging

National Association of Foster Grandparents Program Directors

National Association of Mature People

National Association of Meal Programs

National Association of Nutrition and Aging Services Programs

National Association of Older American Volunteer Program Directors

National Association of RSVP Directors, Inc.

National Association of Retired Federal Employees

National Association of Senior Companion Project Directors

National Association of State Units on Aging

National Caucus and Center on Black Aged, Inc.

National Council of Senior Citizens

National Council on the Aging, Inc.

National Indian Council on Aging, Inc.

National Interfaith Coalition on Aging

National Pacific/Asian Resource Center on Aging

Older Women's League

Retired Members Department/United Auto Workers

AFL-CIO Department of Occupational Safety, Health & Social Security

Villers Advocacy Associates

Mr. PEPPER. Thank you very much, Mr. Reilly.

A little while ago a lady sat at my desk here in this building and told me she was 35 years old, she had three children, and she was supporting her mother. She said, "if you look in my eyes you will see the eyeballs have already turned yellow. I have a liver disease. The doctors have told me that if I don't have an operation, a transplant, within the next 6 or 9 months, I will be dead in the next 12 months."

She said, "the doctors to whom I have gone to at the hospital, who do this kind of an operation, tell me it will cost at least $150,000 for me to have this operation—maybe even more." She said, "I have been able to raise $45,000 from kind people who want to help me to live." She said, "I don't know whether I am going to be able to get anymore or not. Can you help me? Is there any Federal program that could give me assistance?"

I got in touch with Mr. Stockman, who was then the head of OMB. He knew more about the Government than anybody else, I thought. He didn't know of any Federal program. He checked up on it, called me back, and said, "I don't know of any Federal aid that she can get."

Now, there was a life that was dependent upon being able to get the money to have an operation that was available from the medical skills and the facilities that exist in this country.

Finally, that lady—I helped her some, and others—finally, a hospital in your State of Massachusetts, in Boston, Mr. Hiam, gave this lady the operation that she needed from a Texas donor. The last I heard of the lady, she was seeking to raise $15,000 to get some sort of treatment that keeps the body from rejecting a transplant.

I thought to myself, now, this wonderful lady has been able to survive, apparently, by good fortune. But I thought of the thousands of people in this country who needed transplants, needed some other kind of expensive care, and were never able to raise the money.

I have always considered life a divine gift, and any life is a precious asset. And to have to accept the fact that I live in a country where you can only live if you have a serious ailment if you can get the money to survive—somehow or another that just doesn't square with Hubert Humphrey's—his great father's—concept, and my concept, and I think the concept, I know of my committee here, and the people of this country.

In the Senate, the first person I ever heard propose a comprehensive health program was the great Senator Robert Wagner from New York. They called it then national health insurance. And, of course, the proponents of some special interests in the country branded it as socialized medicine, which is the first cousin of communism. They meant to imply it was just on the fringe of communism if you advocated anything like that.

Well, it did involve a large bureaucracy. Since that time, many of us have continued to believe in the principle that everybody should be able to meet their complete health needs through an insurance program. Insurance is a private enterprise institution in America. We insure our homes. We insure our businesses. Why can't we insure our health against catastrophic illness. It is a catas-

trophe when an ordinary family has a home burn down, so we have an insurance program under which that catastrophe can be minimized for the injured person.

So we are working toward building a system. I want it to be conceived primarily by private enterprise because it is primarily a business proposition. We have got to provide money to pay for the health services that we want to be expended upon needy people.

Our committee here asked Dr. Bowen, the Secretary of Health and Human Services, about this and he came over and testified before our committee—the first he has testified at since he has been in office. We asked him, will you please expand your study of catastrophic insurance coverage to include complete care, comprehensive care, for all people, for all needs?

In one of my Florida visits, I sat across the table from a lady who said, "I am a professional obstetrician." She said, "you would be surprised to know how many children are born with some sort of defect which could be cured or corrected if they could get access to the proper medical care." But she said most of the mothers are poor. They don't even know where to find the hospital, let alone have the money to pay for the operation. The result is that the child grows up with the impediment of the handicap that he or she had in birth.

The other day we had a horrible, beastly thing occur in my district. A lovely lady, a nurse, from England, was visiting in our area. Some beast grabbed her away from the telephone booth, threw her into a stolen van, took her out and thought he had killed her, and left her for dead in the woods. Fortunately, she was discovered and is making a slow recovery.

I don't know whether that fellow, who is wanted in Maryland for two or three murders and rapes before he came to Florida, I don't know whether he is one of those children that had a defect of some sort, that maybe in time might have been cured. And that woman and his other victims might have been spared.

So, we are concerned about all types of health care.

Our bill is a beginning in that direction—our bill, 4287. We don't propose to raise any more money but let the elderly pay the $600 on an average that they spend for their medical care besides what they get from Medicare. But put it all into the same pot, as it were, and do what the Chrysler Motor Co. is doing—contract out the rendering of these services generally to the private providers with proper supervision—a program recommended by a great former Secretary of HEW, Joe Califano.

So we will try to get those data from the National Academy of Sciences as to how much it would cost. And then under our bill, H.R. 4287, the States, by asking to do so, may be incorporated in the program, take advantage of it, by paying 90 percent of the estimated amount they would spend upon their average patient in the coming year from the time they ask for enrollment.

They will save money and then we will put the money that the Federal Government is putting into Medicaid and the money that the States are putting in, and directly through Medicare will supervise its expenditures in the way that Chrysler is doing now. We will try to provide the medical care that the people of this country should have.

I don't see how we can go along with good conscience without making the utmost effort to try to establish some kind of a system like that.

Now, we are not borrowing any system from anybody else. I understand there are merits in other systems in the world, but we want this to be an American system, conceived and initiated by American private enterprise that has built the best economy in the world, the best economic system in the world. We accept the principle of insurance. All we need to do is make the application of it to the health needs of the people of this country.

So, now I just want to ask two or three questions. I am sorry to take the time of my colleagues to make such a long comment, but, first, do you generally agree that we need to find some way to give catastrophic coverage to the people of this country? Do all of you agree to that?

Mr. REILLY. I certainly do.

Mr. PEPPER. Good.

Second, do you know—I am not discrediting any insurance company. The insurance companies I know have made many advances—the marketplace is beginning to demand new insurance products, and even the middle class can't afford to pay for the medical care that they need today.

One of my brothers who regrettably passed away 2 years ago was in a hospital back home for 6 weeks. He got a bill for $26,000. Now, you take a man working for some corporation making $40,000 or $50,000 a year, way above the average, owning his home and a couple of cars, his furniture and everything—maybe got $50,000, to $100,000 in liquid assets, way above the average. Suppose he gets the news that I got one day, that my wife had cancer. It cost me $40,000 just for extra nurses to give her the doctor's recommended nursing care that the hospital didn't provide.

So even a well-to-do middle class person can be ruined. Now the President in his last message, said that he wanted the Department of Health and Human Services to investigate comprehensive coverage. The language was broad. We hope everybody can join in and ask the Secretary of Health and Human Services to expand that concept from that little one-tenth of 1 percent that his proposal would cover. We said, Mr. Secretary, will you please make your study comprehensive, at least for all the elderly? He said he would. And we hope we can get the data together.

I have been tempted—I am not of the President's party, but since he made that statement—I have been tempted to go to the President and say, Mr. President, if you want to leave a legacy that would make your name shine in heaven as well as in the hearts of the people of this country, see to it that before you leave the White House there is a comprehensive medical care program in effect that will give catastrophic coverage to every man, woman and child.

Mr. REILLY. Mr. Chairman, the urgent need for progress in this area is illustrated by what we are hearing more and more from hospitals about cases such as the one you cited about the lady who needed the very, very expensive operation. In the past there has been an informal cost transfer system where, if the person clearly could not come up with the money, the hospital would go ahead

with the operation and would up the bill somewhat for a variety of other patients in the hospital to compensate. In effect, the other patients would, never knowing it, wind up paying a piece, a small piece, of that very large bill, so that the hospital would come out whole.

What we are hearing from hospitals now is that that it is increasingly impossible for them to continue this informal cost transfer, since the prospective payment system has been introduced under Medicare. They tell us that they no longer have the flexibility to do it. This will create more severe pressure on those who encounter catastrophic costs.

Mr. PEPPER. Take an expanded system.

Mr. REILLY. That is right.

Mr. PEPPER. We have got to bring our hearing to an end. I just wanted to ask one question. I started to say a minute ago that the insurance companies have been progressive. They have been responding to the demands of the marketplace. But do either one of you know of any insurance company that really gives comprehensive catastrophic coverage in any policy that it proposes? Do you know of any?

Mr. HIAM. No.

Mr. PEPPER. Do any of you know of any?

Mr. REILLY. I think the collective answer is no.

Mr. PEPPER. I don't know of one. Thank you.

Thank you, gentlemen, we are most grateful to you for this wonderful testimony you have given this morning.

Mr. Wyden.

Mr. WYDEN. Thank you, Mr. Chairman. Very quickly so I can get it for the record.

Mr. Pomeroy, my understanding is you were on the special task force and insurance commissioner relating to the Medigap insurance. And, this disbanded—the State Association of Insurance Commissioners disbanded their special task force.

What kind of message does this send? Does this send a message that the State Commissioners don't think this is a serious problem anymore, or what is your appraisal?

Mr. POMEROY. Mr. Chairman, Congressman Wyden, not at all. In my prepared text I just addressed that. The task force on Medicare supplement and other limited benefit plans had a subcommittee do a study of whether variations on the Baucus amendment model for regulating Medicare supplement insurance were effective in reducing the number of complaints received. That study really, either because of the fault in the survey design or something, did not really reveal that any particular variation off the Baucus amendment format proved discernible results in terms of complaints received by the department. That is all that was concluded by that subcommittee, and it was disbanded—it was by no means giving the industry a clean bill of health. I was concerned that might be suggested. That was not in fact the case.

Mr. WYDEN. I am happy to yield to the gentleman from Ohio.

Mr. REGULA. Mr. Chairman, I want to tell you that I am going to convey to the President your suggestion that he could add one more State, namely, heaven, to his total.

I am interested in the fact that you had apparently some good success in Massachusetts in addressing this at the State level, which historically has been the place in which insurance of all types has been regulated. I am wondering, and I would be interested in hearing from Mr. Pomeroy and Attorney General Humphrey, why other States aren't picking up?

I remember as a member of the State legislature, we often used model legislation from other States to improve our own legislative response. Maybe you can respond as to why they aren't moving at the State level, given Massachusetts' success.

Mr. HUMPHREY. Mr. Chairman, much of the legislation that we have worked on does parallel Massachusetts. One of the things that we are talking about is just exactly what we discussed here, and that is to try and prohibit the sale of those special specific types of policies such as dread disease policies, and, instead, to require comprehensive policies. That is a minimum standard in Minnesota now, not just a policy and not just a recommendation—it is a standard. You can't sell anything but the comprehensive policy in Minnesota. And that parallels, I think, to a great extent, what Massachusetts has done.

There are other States, though, that I am aware of that just have not been able to reach that kind of agreement. And you do have a wide diversity.

Mr. POMEROY. Mr. Chairman, congressmen, Massachusetts has a different regulatory environment relative to insurance, it is almost unique among all the States in the country, certainly much more extensive regulation than North Dakota and a number of other States that I am aware of.

I am also a former State legislator. I don't think we could legislate in North Dakota the type of regulation that Commissioner Hiam has said that has been so successful in Massachusetts. Again, though, I think no matter what regulatory scheme you have, when you have all of the components that you have got with the marketing of this type of insurance—a confusing product; reimbursement by commission, so you are encouraged to oversell. It is going to be tough to eliminate the problem, no matter which regulatory framework you adopt.

Mr. REGULA. Well, given that fact, how do we attack it? If you say it is tough to handle at the State level, I question that putting the imprint of the Federal Government on it is necessarily going to address that anymore successfully.

Mr. POMEROY. Mr. Chairman, Congressman, I am not at all suggesting that Federal regulation in this area will be more effective than State regulation, not at all.

I do want the committee to be aware that it is an area of great concern to the National Association of Insurance Commissioners, and we are continuing to review it. I, as one commissioner, am darned frustrated about our inability to be more effective.

Mr. HUMPHREY. Mr. Chairman, if I could just respond. I think that certainly national minimum standards could be very helpful to all of us, certainly to my colleagues that I have talked to. And, second, I think that, again, as we have done in our State, if there is a means of shifting the burden of responsibility for not overselling, for determining the suitability and necessity of the insurance pack-

age, so that that burden is placed clearly upon the company that has the expertise, the time, and the ability to make those decisions, that would be very helpful. And it would be helpful to all the States.

One of our problems is when we attempt to go and enforce in Minnesota—many of the companies that are selling are not Minnesota companies—and to just get the information is sometimes very difficult.

Mr. REGULA. When you say minimum standards, are you saying minimum standards as to the way States should regulate, or are you saying minimum standards for the companies that do business in the United States?

Mr. HUMPHREY. It could be minimum standards on the policy, in fact.

Mr. VENTO. If the gentleman would yield. One of the other points here would be to if you have agents that are selling for you to make the company liable for, in a sense, what the agent is presenting, which is a very tough thing to do. But the fact of the matter is that you are trying to go against an agent, he is no longer in business, you take his license away. And the fact of the matter is, that nobody has the residual responsibility. And the senior citizen ends up being the one that is hurt.

Mr. HUMPHREY. Mr. Chairman, if I could just clarify. I know that the Baucus amendment standards are now recommendations, and they are voluntary for compliance.

What I am suggesting is, as in Minnesota we made those policy standards minimums, the laws absolutely say you can't sell anything other than that at a minimum. You can do better—but at least at that level we have some uniform standard.

The problem that we have, Mr. Chairman, is that as you hear more and more these policies are being sold on a national basis. The marketing mechanism is not coming into Minnesota and just selling it to Minnesota. They are selling it nationally. You see it on your television every night. That is one of the key problems.

Mr. VENTO. The point is—if I can just continue, and I will be brief because I know we have another witness—is that the approval, or the, what did we call it, the certification process at the national level—we ought to try it anyway. It is in the law and it ought to be tried. I think that at least it would provide more guidance. And many States haven't done what Minnesota, and apparently North Dakota, have done. We do have a system in our State that classifies the supplemental medical insurance policies from plus one to three. There are four different types of policies depending upon the coverage.

The fact of the matter is, given those types of criteria, then it gives an attorney general or the Justice Department the opportunity to take those issues and litigate them when they are not followed. So that becomes very important. We haven't had that opportunity.

One question I had, Mr. Hiam, what is the cost of that No. 3 policy that you talked about, the Blue Cross/Blue Shield offered per month—per year.

Mr. HIAM. $43 and some odd cents a month.

Mr. VENTO. $43, and that is rated the best policy by consumer—$43 is rated the best policy buy——

Mr. HIAM. Consumer Reports. That has to do, though, with the coverage that it offers. It offers a broader coverage than any other policy.

Mr. VENTO. But I notice that—and I think it was a very telling point when someone said does this really—do you know of a policy that offers the type of catastrophic insurance, or catastrophic coverage that I have? And I haven't. This panel was silent and I think that points out the gap between—medigap follows these, and the Medicare program that we have.

Last night on Frontline there was a program dealing with Medicare and the problems with the middle class, which I would commend to anyone. I just saw part of it but it was excellent. It was just an excellent program.

I have no further questions, Mr. Chairman.

Mr. PEPPER. Thank you, gentlemen, again, very much for your valuable contribution.

We have one last witness—the audience and all of you have been very tolerant—Hon. Robert B. Shapland, association actuary, Health Insurance Association of America, Washington, DC.

Mr. Shapland, will you please come forward? Please take your place at the table.

Mr. Shapland, I am going to have to ask you to do what we often have to do before our subcommittee, to put your comprehensive and excellent statement, I am sure, in the record and give us a summary, if you will, of it, because we are running behind time. It looks like we will just have to ask you if you will try to do that. If you could do so without prejudice to yourself.

PANEL THREE—THE INDUSTRY RESPONSE TO INSURANCE ABUSE: CONSISTING OF ROBERT SHAPLAND, VICE PRESIDENT AND ACTUARY, MUTUAL OF OMAHA INSURANCE CO., ON BEHALF OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA, WASHINGTON, DC

STATEMENT OF ROBERT SHAPLAND

Mr. SHAPLAND. Thank you, I sure will. In fact, I am going to do even better than that. I have completely changed my talk. I was very interested in the proceedings here and I think it calls for a completely different response than my written testimony.

We want to applaud this committee's hearing today, and almost everything that has been said. In fact, maybe we should be asking why this meeting wasn't held earlier. Almost everything that has been said has been supported and pushed by the HIAA for years. We think you might be a little bit behind times in joining us in that support.

We have actively supported eliminating abuse in the selling of insurance, educating the public regarding insurance, and solving the funding problems that face people in long-term care.

Let's talk about what the insurance industry has done in those areas. Even before the Baucus amendment was passed, the insurance industry was active in supporting a model regulation which did the same things as later required by the Baucus amendment.

And, by the way, almost half the States passed that law before the Baucus amendment was approved by Congress.

After Baucus was passed, we were at the forefront in getting the States to adopt that model law in all the other States. Presently, every State has adopted that law. I am surprised that there is some confusion about some States having minimum standards and others not. Every State has the same minimum standard for Medicare supplement policies. There aren't any States that don't have this minimum standard. Those standards have to do not only with knowing the benefits, but sales abuses, and all the other things that were talked about here today.

We support, and always have, enforcing those laws. We don't want laws sitting on the books which are doing no good and which are not being enforced. If there is abuse, that makes us look bad, and we don't want to look bad anymore than you want us to. So we ask that those laws be enforced. If you have cases showing that there is abuse, report them to the insurance department and make sure that those insurance departments enforce the law. They all have laws which ought to be enforced.

Now, it is difficult to conceive that this abuse takes place in light of all of the actions that have been taken by both the Baucus amendment and the health insurance industry, but evidently it has.

But let me tell you about some of the things that we have done to try to curb abuse. There is a law in every State which says that when you sell a supplement policy, you have to do certain things. One of them is to give the applicant this piece of information, called a Guide to Health Insurance for People with Medicare. This was put together by the health insurance industry together with consumer groups and HCFA in order to avoid abuse.

Let me just tell you some of the things that are in this brochure which is simple to read, easily understandable language. I will read some of the titles about some basic things the Medicare beneficiary should know.

It says insurance to supplement Medicare is not to be mistaken for a Government service. It makes it very clear that anybody contacting them concerning Medicare supplement coverage is not contacting them on behalf of the Federal Government.

The guide poses the question: do you need private health insurance in addition to Medicare?

It responds: not everyone. It says right up front: not everybody needs this coverage. And it goes on to explain different kinds of policies and preexisting conditions, and so on.

It even warns people—it says that some companies ask for detailed medical information. If they do and you submit that information, the company might cancel your policy or rescind it. The guide tells them this—in fact, it warns them of this.

Now, in addition to this guide to Medicare supplement, every company, when they sell such a policy, has to provide another kind of information called an outline of coverage, and it covers several areas. First, it says that the agent is not connected with Medicare. So consumers are told twice in this regard. It goes on to give a complete explanation of Medicare benefits, what Medicare doesn't pay, what the supplemental policy pays, and what is left uncovered. So

there can't be any confusion about what the policy pays and what it doesn't pay.

Now, there was a lot of comment here today about confusion over Medicare supplement policies covering custodial care. We are concerned about that, too.

Actually, according to a recent survey 80 percent of the people in the United States that are Medicare recipients think the Federal Government covers long-term care. The insurance industry has been at the forefront of trying to warn people and educate them that they don't have long-term care in their Medicare or Medicare supplement policies. I ask: What has the Federal Government done to assist us in this area?

The outline of coverage states: This policy does not provide benefits for custodial care. That is on the first page.

On the second page it gives a long outline, a litany of things it does not cover. What other industry gives the public warnings about what their product does not do? I think the health insurance industry can be very proud of the action that is taken in this regard.

It says: This policy does not cover private duty nursing, custodial nursing care, intermediate nursing care, and so on. We are telling people right upfront so that our agents and people cannot go out and lie to people. That doesn't mean that somebody might not lie, but those persons should be prosecuted. We are doing everything we can humanly do to stop these practices.

If you know of something else we can do, we are more than willing to try to do it.

The Guide to Health Insurance also states that Medicare does not cover certain kinds of care.

If it wasn't for the private industry giving this to the public, they wouldn't have that information.

The American Association of Retired Persons is probably in the forefront of protecting the elderly—that is the whole reason for their organization. They sell Medicare supplement policies to fill the gaps of Medicare—not long-term care, that is not what Medicare supplement policies were ever designed to do.

I think the suggestion that such an organization would support misleading policies is wrong. I think the answer is that there is a need for further education regarding what supplemental policies provide and what they don't provide.

I think that it has been brought up here, and rightfully so, that the biggest problem facing the elderly today is long-term care costs. That cost has not been met by either Medicare or the private insurance industry. There is a reason for that—it's tremendous cost. The problem is not that people don't need the coverage. The problem is how to finance it.

The Health Insurance Association has been working for years in conjunction with the AARP and many other organizations to study the cost problems and the financial solutions associated with long-term care coverage. We are ready to help you in your deliberations on this matter. We have lots of proposals and we would like to move forward.

I think the time is now to let you ask me some questions. I hope I have stirred some questions in your minds. I have so many things

that I would like to say in response to things that were said here today that I thought were somewhat misleading.

[The prepared statement of Mr. Shapland follows:]

PREPARED STATEMENT OF ROBERT SHAPLAND, VICE PRESIDENT AND ACTUARY, MUTUAL OF OMAHA INSURANCE COMPANY; ON BEHALF OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA

I am Robert Shapland, Vice President and Actuary for the Mutual of Omaha. Today I also represent the Health Insurance Association of America. The HIAA is a trade association, representing some 335 insurance companies. Our members write over 85 percent of the private health insurance provided by insurance companies in this country. Many of these companies, including my own, also design and underwrite private insurance plans that coordinate with the Medicare Program. Mutual of Omaha has nearly 20 years of experience in that particular business.

The HIAA appreciates this opportunity to comment on the status of private Medicare Supplement health insurance coverage. We would also like to comment on proposals to amend the current Medicare program to provide catastrophic medical coverage since the two topics are related. Whether to provide greater financial security for the existing program in the years to come, or to expand or restructure Medicare benefits, the subject of reforming the Medicare program seems to be a high priority topic these days. The private health insurance industry is spending an extensive amount of time this year considering various alternatives in this area and developing reactions to the proposals spawned by other similarly interested parties.

If I could summarize for you the prevailing conclusion from our industry's assessments of Medicare and its present condition, I would have to say that we see no compelling need to begin a major overhaul. In our opinion, the current combination of private and public coverage is serving the public well. So, since the system obviously is not "broken", a major "fix" hardly seems warranted.

From all indications, the joint Medicare/Medigap program enjoys a remarkably high degree of public approval. The Medicare program is being efficiently administered by a successful partnership between the Health Care Financing Administration and the private insurance industry. You should be mindful, however, that in the past few years, underfunding of Medicare carriers and intermediaries is seriously undermining that venture in cooperative management.

The fact that seventy percent of Medicare beneficiaries use private supplemental insurance to fill the program's ever increasing deductibles and

co-payments attests to its success and to the practical accommodation of public and private interests. Since an additional 12 percent of the elderly are covered by Medicaid, only 18 percent of those over 65 are without protection against gaps in Medicare. It seems to me that this points out an area where some limited government action may be appropriate; i.e., to further assist those few who are not able to cope financially with the rising coinsurance, deductibles, and out-of-pocket costs associated with Medicare via the purchase of supplemental insurance. Although this problem for the elderly poor should not be underestimated, it should not be the sole reason for a major overhaul of a smoothly operating program.

MEDIGAP INSURANCE: A PUBLIC/PRIVATE SECTOR SUCCESS STORY

We are proud of our record in providing supplemental coverage to the Medicare program so that the Medicare beneficiary can feel confident that his or her health care needs will be met in the future. There have been some assumptions in the past that private insurance is confusing and duplicative. This premise is invalid. A 1983 HCFA study of the effectiveness of state regulation of Medigap insurance found that duplicative coverage was rare. Of the millions of policies presently in force, we are aware of only a handful of alleged violations brought to the attention of HCFA. Further, upon investigation, the majority of these cases were closed because they didn't warrant federal action. HCFA coordinates review of alleged violations of federal statutes together with the Federal Trade Commission and the Postal Service. The HIAA feels that this process is adequate and that no new federal regulatory activities are warranted.

HCFA's findings reflect the tremendous efforts made by state insurance regulators and the insurance industry in response to events of the late 1970s concerning agent sales. In 1977 individual state insurance regulators accelerated agent enforcement procedures to curtail sales abuses. In 1979 HIAA's president wrote all member companies and insurance regulators calling for joint efforts to remedy sales abuses by a few, but nevertheless embarrassing number of agents. That same year, the National Association of Insurance Commissioners appointed a special consumer-oriented Advisory Committee on this issue, which included representatives from HEW, the FTC, consumer and senior citizen groups, and members of the insurance industry. As a result of the Advisory Committee's efforts, the NAIC then adopted model state standards later embraced on the federal level in the 1980 Baucus Amendment. Consequently, virtually all Medicare Supplement policies now on the market meet or exceed those standards.

Additionally, this multi-interested Advisory Committee developed the Guide to Health Insurance for People with Medicare, presently available through HCFA. Current state law requires that this simplified buyers' guide be provided to purchasers of Medicare Supplement coverage, along with an outline of coverage depicting gaps in Medicare coverage and how particular Medicare Supplement policy benefits relate to these gaps. Also, current law requires delivery of a special notice when replacement or addition to existing coverage is involved. Mr. Chairman, we would be glad to furnish the Committee with examples of these materials upon request.

Further, state law requirements dealing with Medicare Supplement policies offer the beneficiary the opportunity to return a policy within 30 days of purchase, as well as receive a full refund. Also, state laws dealing with Medicare Supplement policies require high loss ratios, truth in advertising, fair trade practice settings (including sales, underwriting and claims practices, and simplified policy language requirements), and other valuable consumer protections.

To ensure that all of these controls are adequate, an NAIC subcommittee recently surveyed state insurance departments regarding citizens' complaints related to Medigap insurance. This survey indicated that the limited number of complaints were not the result of any deficiency in NAIC model laws.

This same type of process outlined for Medicare Supplement in protecting the aged is being undertaken regarding private long term care insurance. Current efforts center upon developing regulations that will appropriately control the marketplace, yet facilitate experimentation and exploration of what consumers want to purchase in the long term care field.

WHAT MEDIGAP POLICIES COVER

Private Medicare Supplemental policies typically cover such out-of-pocket costs under Medicare as co-payments and deductibles for hospital and doctor services. In keeping with the Baucus Amendment to the 1980 Social Security Disability Act (P.L. 96-265), the states now require Medicare Supplement policies to meet certain minimum standards, as follows:

-- Coverage of Part A coinsurance for Medicare eligible expenses for hospitalization from the 61st day through the 90th day in any Medicare benefit period;

-- Coverage of Part A coinsurance for Medicare eligible expenses incurred during use of Medicare's lifetime hospital inpatient reserve days;

-- Upon exhaustion of all Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 90% of all Medicare Part A eligible expenses for hospitalization for up to an additional 365 days; and

-- Coverage of 20% of the amount of Medicare eligible expenses under Part B, subject to a maximum calendar year out-of-pocket deductible of $200 and a maximum benefit of $5,000 per calendar year.

Bear in mind that these are purely minimum standards, and that insurance companies are not precluded from the inclusion of higher levels of coverage or additional benefits. In fact, the vast majority of plans exceed these minimum standards.

SUGGESTIONS FOR ENHANCING THE VALUE OF MEDICARE AND MEDIGAP BENEFITS TO BENEFICIARIES

If the federal government wants to enhance the value to beneficiaries of their Medicare benefits as well as their private Medicare supplement policies, the Health Care Financing Administration could do much more to identify for Medicare beneficiaries those physicians and other providers who regularly accept assignment. By helping beneficiaries find Medicare participating physicians, HCFA could greatly relieve the high insurance costs and out-of-pocket costs that stem from provider balance billing. HCFA could publish directories with the names of participating physicians and provide toll-free hotlines. It could also develop incentives for electronic billing of physician claims and for streamlining the coordination of billing for Medicare and Medigap benefits.

The HIAA also endorses Medicare's use of more stringent cost containment techniques to help keep that program solvent. For example, we encourage Medicare to be more aggressive with focused utilization review, pre-admission certification and mandatory second surgical opinion programs. These are all steps being used more routinely in private managed health care plans.

TAX INCENTIVES FOR PRE-FUNDING RETIREE HEALTH BENEFITS

One important way both to help the elderly poor and to complement the Medicare program would be to encourage more employers to provide health benefits to their retired workers.

The U.S. Department of Labor reports that currently, only 57 percent of employees in large and medium-sized companies will receive employer-provided

health benefits to supplement Medicare upon retirement. Although this number is expected to grow, coinciding with the growth in the size of the elderly population, federal tax policy is a major reason why many more employers are choosing not to do more for retirees.

The Deficit Reduction Act of 1984 placed limits on the tax advantages pre-funding retiree health benefits. I urge Congress to consider the [illegible] of federal tax policy which discourages employers and employees from entering into financial arrangements today, which would generate greater private capital for the health care needs of tomorrow's elderly. In our mind, employers should be encouraged to provide such benefits by allowing them maximum flexibility and positive incentives to respond to the growing financial needs of their retirees. Pre-funding for retiree health care needs not only helps relieve political pressure to expand government financing of long term care, but promises to be one of the truly promising ways to promote long range financial planning helpful to the develop of an insurance market for a long term care insurance product.

In short, DEFRA's tax provisions on pre-funding retiree benefits is causing employers to curtail the funding of retiree health benefits. I urge you to examine this issue.

PROPOSALS FOR CATASTROPHIC COVERAGE UNDER MEDICARE

A proposal for reforming Medicare favored by the new HHS Secretary, Dr. Otis Bowen would raise the monthly Medicare Part B premium sufficently to eliminate Part A coinsurance on the 61st through life-time-reserve days of Medicare and provide unlimited hospital days. Following are some of our thoughts on this type of a proposal:

1. One of the stated purposes of the proposal is to offer Medigap coverage at a premium less than the private sector. Our review of various Medigap policies shows there are plans in the private market being offered at similar rates, when a fair comparison of similar benefits is made.

2. It is difficult to compare the costs of catastrophic coverage provided by the government with the costs of Medicare supplement coverage provided by the private sector since the latter provides broader benefits such as reimbursement of the Part A deductible, which is currently $492. In any cost comparison, one should avoid comparing apples and oranges.

3. The government might be able to provide catastrophic coverage at less cost than the private sector only if it does so in the form of a mandatory

program. But this is true in any sector of private enterprise where removal of freedom of choice, and therefore marketing costs, involves savings. However, under such governmental monopolies, the lack of competitive pressure often leads to inefficiencies which offset the reduced marketing costs. If the government chooses to expand Medicare coverage on an optional basis with an increase in the Part B premium, it will incur marketing and administrative expenses, as well as adverse selection by high risk beneficiaries, which will severely impact on any cost advantage. In fact, this cost savings is already questionable since some insurers are selling catastrophic coverage at premiums lower than that of the proposed government plan.

4. We think the proposal is in conflict with the basic premise of our Social Security programs. These programs are designed to provide a floor of protection, and it is understood that citizens should be encouraged to buy supplemental protection from the private insurance industry to fill their remaining needs.

5. The proposal could constrict the private sector in its necessary and worthwhile continued experimentation and innovation in meeting the insurance needs of the public, such as coverage for skilled nursing care not covered by Medicare.

6. It would eliminate the public service work of tens of thousands of insurance agents who are performing a most important counseling service to Medicare beneficiaries.

7. A final point in regard to this proposal is our view that Part A and Part B funding should not be intermingled.

Part B of Medicare is partly supported by general revenues. Part A benefits are not -- and for good reason. Medicare hospital benefits were designed to be totally self-supporting, with payroll tax dollars earmarked for very specific benefits. This was done to protect the political base of the Medicare program, as well as to keep politicians from spending "soft" general revenue dollars for expanded benefits. Any steps that erode this sound principle should be opposed as unsound fiscal policy.

Furthermore, it was only two years ago that the Senate Finance Committee recommended an increase in the Part B premium to help stabilize the long term financing of the program. The HIAA could support an increase in the Part B premium to bring it back in line with the originally intended fifty-fifty

ratio of premium to general revenues. We feel it would be unwise at this point to use up potential Part B premium dollars, which might better be used to solve future trust fund solvency problems.

INSURANCE INDUSTRY INITIATIVES REGARDING LONG TERM CARE

Tragically, the problem few elderly fail to anticipate is that neither Medicare nor private Medicare supplemental policies cover long term care. Proposals to expand Medicare benefits are not a solution because acute care expenses are not the usual cause of catastrophic expenses among the elderly. The real problem is chronic long term care. Based on a recent study financed by the National Center for Health Service Research, for those aged who spent more than $2,000 out-of-pocket, 81 percent of their additional expenses were for nursing home care.

About four years ago, an HIAA Task Force was established to explore this issue. A report, "Long Term Care: The Challenge to Society", produced by the Task Force, is attached. In December 1984, an industry-wide conference was held to build on the task force report and to expose industry representatives to the range of long term care issues from a variety of perspectives. In November 1985, the HIAA joined other national organizations representing the aged, providers and payers in sponsoring a national conference entitled: "Private Long Term Care Insurance - the Emerging Market." The proceedings of that conference are available from our Public Relations Division.

Industry representatives have participated in numerous conferences and hearings called to bring interested parties together to begin a broad based effort to resolve some of the problems. In addition, individual companies are exploring and/or are entering into the private sector market for long term care insurance.

In its deliberations, the HIAA Long Term Care Task Force has identified some of the problems associated with the development, administration and marketing of a long term care product. These problems are not trivial and solutions are not easily achieved. As possible solutions are found, they must be tested in the marketplace to see whether or not they will work.

As noted, the commercial health insurance industry is involved in long term care financing. For example, the Fireman's Fund has been test marketing for 10 years and currently has 12,000 to 15,000 policies in force. Over the years, their new sales have been modified to reflect experience and various state regulatory restrictions. Coverage is for maximum confinement of 4 years

in a skilled nursing facility, a daily benefit of up to $70 and a 20 or 100 day elimination period.

The United Equitable Insurance Group has marketed some form of nursing home product since the mid '70s, and current policies in force exceed 60,000. Their original plan covered one year of skilled care, but their current plan covers 4 years of skilled care and up to 12 months of intermediate or custodial care at a reduced level of reimbursement. Recent entrants into this market are offering up to 5 years of coverage with no reduction for custodial care.

Each venture into the marketplace provides the industry with additional information on the feasibility and viability of private extended care insurance programs.

Long term care may well be the major health policy issue in the coming decades. The industry and individual companies are exploring the problems and seeking solutions. Both government and private resources are required to meet current challenges and plan for the future needs of our expanding elderly population. The Health Insurance Association of America stands ready to join in the public debate and offers its assistance to this Committee as it deliberates this pressing national problem.

Long Term Care:
The Challenge to Society

Health Insurance Association of America
1984

Introduction

In 1983, the Health Insurance Association of America (HIAA) completed a comprehensive two-year study of the social and economic impact of the "graying of America" on the nation's long term care resources.

A number of factors prompted this initiative, including the growing aged population, changing family composition and lifestyle, and the escalating cost of public and private health care programs.

Above all, the HIAA recognized that the problem is societal in scope and defies solution by any single institution, public or private. Within this context, pressures are clearly increasing on the private health insurance industry to play a significant role in providing long term care benefits to the public.

Opportunities and challenges in the development and marketing of such programs are fully explored in the Association's study.

The nation's elderly are a rapidly growing segment of the population. Currently, there are just under 26 million Americans aged 65 or older, about one in nine of the general population. By the year 2000, there will be about 34 million older Americans, or one in eight.

Senior citizens comprise 85 percent of nursing home residents. Moreover, the frail elderly, those 80 and older, are increasing at a faster rate than the general aged population. Some 5.1 million older senior citizens are expected to increase to 8 million by the end of the century. The chronic diseases, and accompanying functional disabilities of the aged, imply an increased need for long term care services.

Changes in Family Composition and Lifestyle

At the same time, there have been major changes in family composition and lifestyle. We live in an increasingly mobile society. Far greater numbers of women are entering the work force. Marriages are occurring later with fewer children and more divorces.

If these trends continue, we can anticipate reduced reliance on family support systems and increased reliance on organized long term care modes. This, in turn, spurs heightened concern about the financing of long term care services.

Long Term Care Cost Inflation

Not only has the aging population grown rapidly, but expenditures for long term care have escalated even more dramatically. Stated in current dollars, in 1980, $20.7 billion was spent for nursing home care, double the $10.1 billion in 1975. Government spending in this area, which accounts for more than 50% of the aggregate, also doubled from $5.7 billion to $11.6 billion over the five-year period.

Out-of-pocket expenditures of $6.7 billion in 1980 are also twice the amount spent five years earlier, while insurance expenditures for nursing home care rose from $78 million to nearly $200 million over the same period. With nursing home expenditures estimated to reach $76 billion by 1990, the financing of long term care thus becomes a critical issue.[1]

For the foreseeable future, government will continue to be concerned about escalating program costs at the federal, state, and local levels. At the same time, inflation in nursing home costs, rising at a higher rate than the general economy[2], implies that fewer people will be able to pay for services from their own personal resources.

In such an environment, there is growing public expectation of the availability of long term care products within the private market. The feasibility of private market approaches is already being explored [illegible] groups. For example, the [illegible]nal Center for Health Services Research has conducted a study which is being described as an assessment of the extent of senior citizen demand for insured long term care benefits.

The alternative to private sector involvement in some form may well be complete government control over long term care in the future. Under such a scenario, political exigencies would determine the lifestyle for those needing long term care.

[1] *Health Care Financing Review*, Health Care Financing Administration, Fall 1980, Winter 1981, September 1982

Working Papers on Long-Term Care, prepared for the 1982 Under-Secretary's Task Force on Long Term Care, Department of Health and Human Services, October 1981

[2] Between 1975 and 1980

Nursing home expenditures grew 105%
Consumer Price Index grew 53%
Gross National Product grew 89%

Definition of Long Term Care Services

One of the first tasks of the HIAA study was to identify those services which could be included in a long term care insurance plan. An overriding concern was that the availability of long term care coverage would create incentives to place more patients in a nursing home setting and/or raise health care costs. Therefore, a full range of institutional and non-institutional services was considered and the following definition adopted:

"Long Term Care can be defined as a complex and interrelated array of health, health-related, and social services designed to provide preventive, therapeutic, rehabilitative, supportive, and maintenance care for individuals of all ages who have chronic physical and/or mental conditions which impair the individual's ability to function at his or her own optimum levels of mental, physical, and social functioning."

The key factor in long term care is not age, but functional dependency. Such functional dependency is expected to exist for a minimum of three months.

The goal of long term care, whether rendered in an institutional or non-institutional setting (or a combination of both), should be to restore the individual to optimum functional levels. In addition to medical care services, long term care services include:

- *Homemaker Services*—cooking, shopping, laundry, home management;
- *Chore Services*—less frequent tasks related to home maintenance;
- *Social Services*—guidance in social or emotional problems, advice in financial or legal matters, transportation;
- *Health Related Services*:
  1. Nutrition and health education;
  2. Personal Care Services: bathing, toileting, feeding, assistance in walking, exercise, medication;
  3. Occupational Therapy: medically directed activities to promote the restoration of useful functioning;
- *Skilled Services*:
  1. Physical and Speech Therapy: use of physical or chemical agencies and devices to relieve pain, restore functioning, and prevent loss of use of a part of the body;
  2. Skilled Nursing: administration of medicine, changing of catheter and dressing, evaluation of condition;
- *Housing Services*—provision for continued housing allowances for those undergoing extensive in-patient rehabilitation; group or congregate living arrangements, including social care and dining and service facilities. Some of these might be feasible in long term care products. Others may prove a serious problem for the insurance industry.

Critical Assumptions

Following the identification of nursing home services, the HIAA assessed the present and future environment, based upon two assumptions:

1. Status Quo

Currently the government plays a major role in reimbursing for long term care services, particularly through the Medicaid program. It was felt that incentives inherent in Medicaid preclude development of viable private sector options. Medicaid is already viewed by many as a national coverage program for long term nursing home care, used by far more than the low income population usually thought of as Medicaid's primary clients.

The individual's ability to plan for the transfer of assets expands the number of persons eligible for long term care benefits under the program. Public programs are viewed as a "safety net", a protection against the catastrophic costs of care. Therefore, the HIAA concluded that significant change in public policy in this area is necessary if market initiatives are to be expanded.

2. Reduced Medicaid Involvement

The potential for health insurance type products becoming more widely available might be increased if Medicaid was to become viewed as a less viable option by middle income individuals. Such an occurrence could result as an adjunct to government actions to reduce expenditures by: 1) establishing more stringent eligibility criteria; 2) reducing the type, quantity, and/or quality of covered services; and 3) regulation against and/or greater control over divestment of assets.

In this environment, demand could be stimulated for private long term care coverage by senior citizens, families who want to purchase protection for elderly parents, and younger persons looking to future needs.

Statement of Principles

The HIAA, accordingly, has developed a set of principles for the financing and delivery of long term care services. These principles are:

1. Payment for long term care services should encompass an appropriate mix of public and private funds.
2. Public policies should stimulate private sector involvement in long term care.
3. Public programs and private insurance should provide effective protection against those costs of long term care services they are designed to cover.
4. Every effort should be made to restore physically and mentally impaired persons to their optimal level of functioning.
5. Maintenance of independent living in a community setting should be encouraged where feasible.
6. Long term care should be available in a range of settings, levels of care, and organizational structures to be responsive to the needs of the public.
7. Family and social support services should be utilized to the greatest possible extent, with appropriate incentives for such support.

Major Factors for Consideration

In examining the potential role of the private health insurance industry, the HIAA addressed the various problems of developing, administering, and marketing long term care products.

The Assessment of Needs

The older person often has multiple physical problems, sometimes accompanied by some level of mental impairment. Frequently, the need for assistance in daily activities, such as eating, dressing, walking, and local travel, is more pressing than medical care.

Thus, the assessment of whether an individual requires institutional care and the level and type of care that is needed often involves subjective criteria. In many instances, the patient progresses from need for highly skilled health professional services to lower levels of custodial care as the aging process continues.

Since need, and therefore eligibility for benefits, is not static, health insurance programs should be flexible, reflecting the dynamics of a long term care situation.

Custodial vs. Medical Care

Custodial care is often necessary as a result of physical or mental disability or other deterioration resulting from the aging process. Insurers have long recognized the critical link between custodial care and medical care, and have had considerable difficulty defining eligible services under Major Medical and other benefit plans to deal with the "gray areas" linking the two categories of care.

To remain financially sound requires that insurers generally limit benefits to medical care, with custodial care covered only where necessary to help individuals achieve an optimal level of functioning.

Definition of Provider Roles/Types of Care

Health care provider roles have to be more clearly defined for appropriate placement and determination of eligibility for benefits. For example, nursing homes perform a variety of functions, from housing and social support for the frail elderly to the monitoring of complex medical conditions. There is a need to clearly delineate their functions and whom they should serve.

Also needed is a more precise definition of the various types of care, including skilled, intermediate, day care, home health and hospice care.

Adverse Selection

Adverse selection, from an insurance perspective, occurs when premiums cannot cover claims, because too many of the policyholders are of higher than average risk. A fundamental principle of insurance is that adverse selection must be controlled if financing of an insurance plan is to be actuarially sound. The problem is particularly difficult when considering long term care benefits.

Individuals have thus far shown little evidence of acknowledging the risk of chronic disability. Neither have they demonstrated willingness to plan for financial protection against the cost of long term care services. Therefore, it can be anticipated that the market for long term care products without significant change in

public awareness may be concentrated in high risk segments of the population.

To minimize this problem, health insurers believe it is necessary to educate the potential population in need of long term care services of the risk they face. Even with such heightened awareness, insurers will probably need to emphasize individual underwriting, pre-existing condition clauses, upper age limits on eligibility, and the development of long term care benefit plans attractive to younger age groups in order to produce actuarially sound products.

Induced Demand

As with any new product, long term care coverage, if widely sold, will create demand far in excess of what is currently experienced. The accelerating growth in the nursing home industry during the 1970's was, in large measure, due to the expansion of public programs that finance long term care. The impact of private sector participation is expected to accelerate pressures on utilization.

Furthermore, there is a strong possibility of efforts by family, friends, and charitable institutions to obtain reimbursement for care previously rendered free of charge. The induced demand for home care services may well be even more serious than induced demand for institutional care.

Ways to limit induced demand need to be found. Potential mechanisms have already been cited, ranging from stringent medical necessity language and uniform definitions of types of care to plan design features and claims review specifically designed to ease the problem. In addition, insurers would probably expect insured individuals to share a portion of the cost of needed care.

Premium Pricing

Pricing difficulties abound in the area of long term care. Benefits may be paid out years after premium levels are set. Setting premium rates, therefore, has to reflect dynamic risks, such as changes in the cost of care, consumer tastes, consumer incomes, and technological advances. Premiums that accurately recognize these risks in addition to the standard risks of age, sex, and health status might be so high as to limit marketability to a small segment of the population.

Among the possible approaches to minimizing risks are: automatic premium and benefit adjustments; additional policy provisions enabling insured individuals to increase their coverage without medical underwriting; and marketing the long term care product to younger age groups.

Regulatory Considerations

The current regulatory environment is not responsive to the variety of benefits required in long term care. For example, in California, home care benefits are deemed to be more akin to disability coverage than to traditional hospital, medical, and surgical expense protection.

In addition, sales to younger age groups may entail prefunding with associated cash accumulation. Thus, cash values would probably have to be considered. This issue is not addressed under current state legislation and regulation governing health insurance.

Clearly, a practical regulatory framework needs to be shaped to accommodate the successful underwriting and marketing of long term care coverage.

Evaluation of Potential Products

The HIAA evaluated a number of potential model long term care products. These models vary by age at issue, method of benefit payment (i.e. fee for service or indemnity), and various premium and benefit options.

After thorough analysis, the HIAA identified several more probable approaches. These approaches would include the following features: meaningful deductibles and/or elimination periods; adhering to reasonable individual underwriting standards and pre-existing condition clauses; carefully defining levels of care and medical necessity; guaranteed renewability of policies; inflation protection, such as automatic premium and benefit adjustments and the right to increase coverage without medical underwriting; providing for periodic recertification of benefit eligibility; and imposing upper age limits on age at issue of policy to reduce adverse selection.

The specific approaches are:

- *Indemnity benefits for long term care services, with premiums beginning prior to and continuing beyond age 65.* This product can be priced under the assumptions cited above. However, its marketability to younger age groups without a cash accumulation feature is questionable.

- *Indemnity benefits for long term care services, with premiums beginning at age 65 or over.* This type of plan is currently being offered on a limited basis.

- *Indemnity benefits combined with a lump sum settlement option, with premiums beginning prior to age 65.* Under this arrangement, it would be possible to expand coverage after age 65.

- *Indemnity benefits combined with a lump sum settlement option, with a single premium after age 65.*

- *Indemnity benefits combined with a lump sum settlement option before age 65 and annuity benefits after 65.* This approach would be geared to younger people interested in both long term care benefits and retirement income protection.

- *Indemnity long term care benefits combined with annuity benefits and single premiums after age 65.* Annuity benefits would begin immediately. Such a plan, however, would require a large premium and, hence, possess limited appeal.

Other Options

Long term care services could be funded through a variety of existing insurance products, such as whole life policies. Non-insurance vehicles could also be explored. Individual Health Accounts, a tax preferred capital accumulation mechanism dedicated to health care, is a concept which has been proposed and deserves further consideration.

Life Care Communities are receiving increased attention as a source of protection for the elderly. In effect, these communities employ insurance principles by spreading the risk of loss equally among all residents. A potential role exists for the health insurance industry to financially underwrite and manage such programs.

Recommendations

Based upon its evaluation, the HIAA recommends the following:

- Exploration of a public-private sector partnership to assure financial protection against the costs of long term care services.
- Public policy initiatives to encourage greater private sector involvement in the delivery and financing of long term care.
- Public policy initiatives to provide positive incentives for private sector experimentation in the financing of long term care services.
- Broader education of the public of their potential long term care needs as an integral part of comprehensive retirement planning.
- Public policy initiatives to encourage individual and family responsibility in this area.
- Continued state responsibility for indigent individuals in need of long term care services.
- The creation of a regulatory environment conducive to the development and marketing of long term care plans.

Conclusion

Financial protection against the costs of long term care may well become the dominant financing issue in the coming decades.

To successfully market programs responsive to this need, long term care coverages must prove attractive to younger individuals. Capital accumulation plans with cash settlement options, and/or the ability to convert to a combination retirement and long term care benefit, may stimulate demand among younger age groups. In any event, a great deal of work remains to be done by private insurance companies to design benefit plans for long term care.

The continued escalation of health care costs remains a concern for acute and long term care services. In large measure, the rapid growth of the nursing home industry in the 1970's was due to the expansion of public programs that financed long term care, producing well-documented strains on government budgets. New private products may fuel yet another round of inflation in long term care costs, threatening the financial integrity of private and public programs.

Finally, changing demographics and budgetary constraints may force a reexamination of the extent of individual and family responsibility to meet long term care needs. Tax incentives and other public measures should be considered to stimulate increased consumer involvement.

Clearly, the health insurance industry stands ready to participate in the public debate and in the resolution of these critical issues.

Mr. WYDEN. Mr. Chairman.

Mr. PEPPER. Excuse me just 1 minute.

Mr. Shapland, I am advised by the staff that only 40 States have a requirement that agents show a guide to the prospective customer at the time they make the presentation.

Mrs. Simmons and none of the witnesses here today, apparently, mentioned to any guide that had been exhibited to them. Does the Insurance Association—you have an Ethics Committee, don't you, the Ethics Division of the insurance industry, something like that?

Mr. SHAPLAND. I guess I can't speak to that. I am sure that the Health Insurance Association of America has an Ethics Committee.

Mr. PEPPER. My information is that it is not the majority of the companies. I don't mean to demean the insurance industry in any sense of the word nor does this committee.

Mr. SHAPLAND. I understand that.

Mr. PEPPER. But we do have it looks like irrefutable proof that there are some companies that are on the fringe of, or the edge of, ethics. We had evidence that a few of them actually trained their agents in making these fraudulent pitches to prospective clients.

Mr. SHAPLAND. We join with you in castigating those companies. We think that those companies should be stopped. There are laws in every State that say those companies can't do those things.

Mr. PEPPER. I would recommend to the industry the idea of doing everything you can to enforce discipline—and having ethical observers in the sale of insurance policies, particularly to elderly people who may be in some way or other handicapped, when a businessman might be more able to assert his wishes.

Now, the last question is: Do you know of any insurance company that offers policies which gives comprehensive catastrophic coverage to their people who buy the policies?

Mr. SHAPLAND. I think in the older age market the answer is no, because companies have shied away—just like the Federal Government has—in offering full coverage for long-term care.

At the younger ages, you know, it is quite common to have fairly broad coverage, covering almost every kind of medical expense, up to a million dollars.

Mr. PEPPER. You say that insurance companies in the last few years have been broadening their coverage?

Mr. SHAPLAND. No, the very comprehensive coverage has been offered for many years to people under 65 who aren't yet eligible for Medicare. That coverage covers almost any kind of medical expense with a maximum benefit of $1 million or more. That is very comprehensive coverage.

But as I say, at the older age levels, both the Federal Government and the private industry has shied away from covering long-term health care costs because of the cost factor. In recent years, the Health Insurance Association has held a lot of meetings and discussions and encouraged the insurance companies, their members, to start selling this coverage, and this is taking place. Almost every day I hear of another company that has come out with a nursing home policy. So this is a rapidly expanding market.

Mr. PEPPER. Mr. Wyden.

Mr. WYDEN. Thank you very much, Mr. Chairman.

Mr. Shapland, I don't want to talk about bills or legislation. I want to talk about problems as we have seen them and then your appraisal of them.

The first thing that we have been talking about today—a major problem in our view, is the TV pitchman, the star kind of situation.

Do you think that the present system, the present nature of the system, is adequate to deal with this very serious problem?

Mr. SHAPLAND. I perceive—and you can correct me if I am wrong—that the thought is that these pitchmen are talking about covering beyond what Medicare and Medicare supplemental policies cover—implying possibly that the coverage extends to nursing home coverage, which no Medicare supplement policies offer.

It is possible that maybe there should be some warning on the TV similar to what our agents have to do, saying that this does not cover long-term care. I think that that would be a step forward in solving the problem that you see. I can see that as being a reasonable thing because we are doing that same thing in all of our sales efforts.

Mr. WYDEN. The second thing that we have heard about at some length today is the problem of the very technical small print kind of language. I have, for example, just one that came to the committee which is really pretty typical. The small print on the limitations, and then the big, bold print in terms of the coverage.

Do you think that the existing system is working well to deal with this particular issue or does something else need to be done in this regard?

Mr. SHAPLAND. I guess I am surprised at the question because I was under the opinion that insurance department codes do not allow you to have smaller print for exclusions than you have for anything else. And in addition to that, these guides and outlines of coverage must tell the persons buying the policy exclusions. So they are told twice.

Mr. WYDEN. This policy I have in my hand is an example of one where what the plan pays the print is a lot bigger than what the limitations says. I am delighted that you, also, don't think that is appropriate.

The last one I wanted to ask you is about this DRG matter that I touched on in my opening statement. Now, most of the supplements cover the part A expenses. But the DRG system that the Congress implemented in 1983 basically changes the role of part A insurance and the need for supplemental coverage.

Now, under the DRG system, no hospital can charge a patient for amounts over the specified DRG rate. That is what the statute says. The only thing that they can charge are for the deductible and for the hospital days in excess of 150 days.

So, the whole Baucus kind of situation and virtually everything that I can see basically, Mr. Shapland, doesn't take into consideration the advent of DRG's, which I think changes the nature of this process very substantially.

Do you think that we have now got to go back and make some changes, either in the educational material or other things we are doing, to take into consideration that the DRG's are in place?

Mr. SHAPLAND. I am glad you asked that because when you made that statement earlier today I wanted to discuss that.

One of us has a misconception of how this DRG system works. I will tell you what my conception is and then maybe somebody can go out and find out which of us is right.

My conception is the DRG system has to do with what the Federal Government pays the hospitals.

Mr. WYDEN. Right.

Mr. SHAPLAND. Not what the patient pays.

The patient still has to pay no matter what the DRG system is and what the relationship is, or formula for the Government reimbursement to the hospital. The patient still has to pay the $492 coinsurance amounts, and so on, if they go to the hospital. So DRG's have not changed anything. The patient still has cost-shaving liability, and Medicare supplement policies cover that liability.

Mr. WYDEN. I agree with you. I think we agree on what the DRG's are all about. But the fact is that under the new system, the beneficiary would still have to pay for the deductible and for hospital days for in excess of 150 days. But these policies seem to not take into consideration that the hospital cannot charge a patient for an amount over the specified DRG rate. So the policies seem to incorporate coverage in that area which is what the leading part of the policy is. I mean, not very many people use more than 150 days. We would agree with that.

I just think that—and, again, I am not advocating any bills or anything of that nature at this point—but somehow we have got to get the word out now that we have got to make sure that our communications to people are in line with the realities of the new way we pay for hospitals. The game has changed dramatically since the DRG's came in from back in 1980 when we had the Baucus amendment.

Mr. SHAPLAND. I have to apologize because I guess I am not following your line of questioning.

The DRG system just changes the relationship regarding how the Federal Government reimburses hospitals. No matter what system there is, the patient is still liable for a certain percentage of the cost based on how many days he is in the hospital.

Mr. WYDEN. Right. But they are the relatively smaller items, things like——

Mr. SHAPLAND. They always have been. The price in a Medicare supplement policy for that part of the coverage after the 60th day is infinitesimal. Most of the premium is for the part B coverage or for covering the part A deductible. So to the extent that average hospitalization stays go down, that there's hardly anybody staying beyond 60 days, that statistic will impact on the experience and the prices we have to charge.

Mr. WYDEN. I won't belabor this. We are anxious to work with you.

Thank you, Mr. Chairman.

Mr. PEPPER. Thank you very much.

Mr. VENTO. Mr. Chairman, just briefly, I think the problem is that you really have addressed is that the supplemental policies tend to mirror the Medicare coverage. I mean, a real problem for people that are trying to cover their health care needs and not-

withstanding whether they have the word catastrophic or custodial, or whatever—I just looked at this ad here as an example—that is hardly ever emphasized, certainly not in the celebrity promoting it on television or in necessarily a magazine, or in the Sunday supplemental.

It may or may not be. I mean, given—I think it gets back to how we really act as consumers when we buy insurance, and the fact of the matter all of this has been in place, I don't know if it is 50 States or 40 States, but will say that whatever the guidelines of the Baucus amendment, they obviously are not mandated, and in any State that those types of coverage have to be in policies.

So, the question really gets back to whether or not, for instance, if an insurance company will stand behind what agents actually represent to take the liability responsibility—I mean, they won't, and they don't want to. I mean, they think they are independent agents.

Mr. SHAPLAND. It is my impression that the courts see a fiduciary relationship between an agent or a company or that a company is liable for the acts of its agents.

Mr. VENTO. I would hope that under these we get some tough guideines. I think that is ultimately what is going to straighten out.

Do you do anything with regards of profitability of any of the life insurance, or any of the—I'm sorry—the health insurance policies, the medigap health insurance policies? Some of them are very profitable. In other words, obviously, they are not paying out the ratio of benefits paid to premium dollar collected.

Mr. SHAPLAND. Every State has a law requiring a minimum loss ratio standard of 60 percent per individual policies and 75 for group. That is enforced from a practical standpoint in every State, because with the advent of increasing deductibles and co-insurance amounts, the liability under Medicare supplement policies automatically increases, which means that you have to increase your premium.

And when you do that, every State requires that you file an actuarial memorandum justifying that rate. And that includes filing your historical loss ratio information. So if you weren't producing that kind of a loss ratio you wouldn't get a rate increase until you do this. So from a practical standpoint——

Mr. VENTO. That assumes the States that may actually approve medigap or supplemental Medicare insurance rates—they don't.

Mr. SHAPLAND. We file and wait for approval, I think in every State.

Mr. VENTO. No, you don't. You don't wait for approval in every State. You don't have that type of control in every State. You file, and in many instances that is the end of it. You just make it public that information and there may be a time period before you can implement it.

Mr. SHAPLAND. I will have to take that information back to my company because we always thought we had to wait for approval in each State.

Mr. VENTO. It is a file and use type of concept.

Mr. SHAPLAND. File and use is in carrier insurance—very rare in health insurance.

Mr. VENTO. Do you, through the commissions paid—is there any effort made there? In other words, if the commission is paid up-front, it is obvious to me that then the emphasis on selling a number of policies, has there been any other type of innovation or method that you have been able to utilize as a different way to pay a commission?

Mr. SHAPLAND. I think insurance companies have the same self-interest as the public in that we don't want our agents to sell a policy and have it be in force for 1 year and then have it switched the next. So we have discussed the possibility of changing the commission structure. But, you have to be aware of the financial environment for that agent. You know, if we do something like that, you are not going to have any agents.

I might say that there is some activity to put limitations as best we know how, on rewriting policies and writing duplicate policies because when an agent does that he is required to provide the policy—another form I did not tell you about—that tells somebody that is having a policy replaced, it gives them quite a few warnings. And if they are adding coverage, it gives them some more information about that.

Mr. VENTO. That, in other words, would recommend it as regulation in a large number of States, but if an agent doesn't do that, the fact is that the individual doesn't get information.

Mr. SHAPLAND. It is my impression that this form in that situation is mandated.

Mr. VENTO. I don't question the good intentions in terms of providing the forms. I am not questioning that. But I think that in practicality in these instances where abuse is occurring that these are more often than not these papers and information is not more adequate.

Mr. SHAPLAND. I agree with you. If somebody is going to lie, steal and cheat, they are not going to follow the law. We agree wholeheartedly—enforce the law and stop it.

Mr. VENTO. If it is a law or a guideline.

Thank you, Mr. Chairman.

Mr. PEPPER. Thank you very much, Mr. Vento.

Mr. Shapland, we thank you very much for your appearance today in giving your important contribution.

Mr. SHAPLAND. My pleasure.

Mr. PEPPER. The Chair would like to file for public observance and for publication the report of the chairman of this subcommittee on the subject of "Catastrophic Health Insurance: 'Medigap' Crisis." It is a rather long document but it has a survey that has been made by the staff of this subcommittee from 12,000 elderly people of the country. So it contains a great deal of very valuable information.

[The report follows:]

CATASTROPHIC HEALTH INSURANCE:
"MEDIGAP" CRISIS

INTRODUCTION AND EXECUTIVE SUMMARY

In November 1978, the House Select Committee on Aging released the results of its investigation of abuses in the sale of health insurance to the elderly in a hearing entitled, "Abuses in the Sale of Supplemental Insurance to the Elderly." The Committee called the problem "a national scandal of staggering dimensions." Testimony revealed that some insurance companies and their unscrupulous agents had become merchants of fear. "Capitalizing on the anxiety about ever-escalating health costs, they have conspired to sell senior citizens multiple, unneeded, duplicative and therefore, esentially worthless insurance policies in supplementation of Medicare, the national health insurance program for the elderly."

A 444-page Committee report, "Abuses in the Sale of Health Insurance to the Elderly in Supplementation of Medicare: A National Scandal," estimated that senior citizens were being taken for as much as $1 billion out of the $4 billion they spent for Medicare supplemental policies each year.

The report concluded that the root cause of the widespread abuse is the fact that senior citizens are afraid. Every day they face the double-edged sword of ever-escalating health care costs and constantly decreasing Medicare coverage. Every day they fear getting sick, going broke, going into a nursing home, or becoming dependent upon loved ones. Motivated by fear, they buy hope in the form of one or more insurance policies, not realizing that there is no policy or combination of policies that they could buy that would plug Medicare's gaping holes and provide them with the comprehensive coverage they desperately want. Understandably, senior citizens are ready victims for fast-talking insurance agents.

The Committee found that it was not uncommon for senior citizens to have 3, 5, 10, 30 and in one instance 91 different insurance policies. In the most blatant example to come to the Committee's attention, a 76-year-old Illinois woman paid over $50,000 in insurance premiums over 10 years and was forced to remortgage her farm to keep up with the premiums. The saddest part of the story was that most policies contained a clause which said that in the case where an individual has more than one policy, only one will pay.

Both the 1978 hearing and its study zeroed in on the pervasive abuse in insurance policies that claim to supplement Medicare. The study was the first detailed national investigation of this problem. It marked the first time that every State department of insurance and the great majority of companies selling Medicare supplemental insurance policies to the elderly had been surveyed. For the first time, large numbers of senior citizens had been asked about their problems with such policies. In addition, the Committee conducted investigations in nine States and the District of Columbia: California, New Jersey, Pennsylvania, Maryland, Illinois, Georgia, Arizona, Delaware, and Virginia -- which at the time accounted for half of America's 23 million aged. Using volunteer senior citizen investigators, the Committee developed firsthand information about how some companies took advantage of the fearful aged.

For example, Margaret Dickson, one of the Committee's senior citizen investigators from the District of Columbia, got some unsettling advice from health insurance agents when she asked them to look over her collection of supplementary policies for Medicare.

Mrs. Dickson was overinsured, but most of the agents insisted that she buy even more coverage. Some dismissed her policies as "garbage" without even looking at them, and pressed her to replace them with as many as eight new overlapping plans. Mrs. Dickson said one agent grilled her "about my tax bracket, my banks, my general financial situation, and then suggested -- oh heavens, I cannot say it -- euthanasia as a solution to long-term health problems." He also asked her to give him power of attorney over her affairs.

What these agents didn't know was that Dickson, a retired receptionist for the Committee Chairman, was working with Congressional investigators. Her "son," who took photographs of the meetings, and the insurance sales "trainee" sitting in on them, were Committee staff investigators.

In 50 such interviews, conducted during the fall of 1978, only eight agents honestly advised, "Gee lady, I think you've already got too much insurance."

Dickson's case was not unique. Investigators found widespread misrepresentation of what policies pay for, high-pressure sales tactics, agents posing as Federal employees,

agents persuading elderly persons to replace adequate policies with new ones just so that he or she could get a higher commission, and companies that paid out very little in benefits compared to the large amounts they collected in premiums.

In addition, the report detailed the activities of four staff investigators who obtained jobs with insurance companies in order to determine whether the abusive marketing practices were company policy.

The study concluded that there were widespread abuses with respect to so-called Medigap insurance policies and the manner in which they were sold to the elderly. It also concluded that there has been a failure to aggressively regulate such abuses by many State Insurance Commissioners. The study likewise concluded that most major insurance companies are not involved in the abuses which filled the report.

The abuses that were found were among the insurance companies who specialized primarily in the sale of individual not group policies. Even then, the most serious problems were generally found among the small and almost anonymous insurance companies that specialized in selling to the elderly.

Following the investiations and hearing by the House Select Committee on Aging, Congressman Claude Pepper introduced H.R. 2602, a bill to curb the proliferation of abuse in the sale of Medigap insurance. The bill, which enjoyed the cosponsorship of 265 Members of Congress, would do the following:

- Establish a program of voluntary certification whereby those policies which meet or exceed Federal minimum standards could be awarded a Federal seal of approval by the Secretary of Health, Education and Welfare. The Federal standards were those recommended by the National Association of Insurance Commissioners plus requirements for economic value. To qualify, group policies would have to return at least 75 cents on the premium dollar to the insured in the form of claims, and policies sold to individuals must return at least 60 percent of the premium dollar. The Federal seal would serve to guide senior citizens as to what is and what is not acceptable policy. The certification program would give the competitive advantage to firms with high standards, and firms with policies which did not meet Federal minimums would be at a significant disadvantage in their sales. States which have enacted substantially equal or higher standards would be exempt from the program.

- Make it unlawful for agents to indulge in two common abuses: "overselling" and "the government look." There were no laws prohibiting an agent from deliberately overloading senior citizens with multiple policies or pretending to be from the Medicare program or from using advertising materials displaying the Federal Eagle and giving the appearance of an official government document. These practices would be outlawed under the bill. Violation would be a felony punishable by up to five years in jail and/or a $25,000 fine.

- Help the States regulate mail order insurance. Under current law in 1977, the States could not effectively regulate Medicare supplementary policies which were sold by mail. The proposal would require mail order firms to first file their policies with the commissioner of insurance in the State in which it would be sold and obtain his or her approval before they could mail their policies into that State. Violation would be a felony punishable by up to five years in jail and/or a $25,000 fine.

The introduction of H.R. 2602 stirred up a strong lobbying effort against its enactment by opponents in the insurance industry. Even with strong bipartisan support for the reform legislation in the House, efforts to move the bill swiftly on the House side were stalled by effective lobbying forces. Staff of the House Select Committee on Aging met with the staff of Senator Max Baucus (D-Mont.) and former Senator John Culver (D-Iowa) to seek support for movement of the bill on the Senate side. Both Senators agreed to introduce S. 1295, a bill identical to H.R. 2602. Between December 5, 1979 and January 30, 1980, Baucus redrafted his bill to exempt from the certification program health insurance contracts established by employers or labor organizations. Baucus also went along with an amendment making clear that effective State programs could replace Federal certification.

The Baucus bill had strong political appeal and was adopted as an amendment to a Social Security disability bill approved by the Senate January 30, 1980. The House passed its version of the Baucus amendment May 22, 1980. And, on June 9, 1980, the voluntary certification of Medicare supplemental health insurance policies became public law (P.L

96-265) (see Appendix H). Among other things, the new law required that a program of voluntary certification for Medigap policies be established; that "overselling" and "the government look" as insurance practices be outlawed; that mail order firms be required to first file their policies with the Commissioner of Insurance in the State in which the policy is sold; and that a study of State regulation of such insurance be undertaken by the Department of Health and Human Services.

It has been six years since the enactment of this landmark legislative reform measure. It has been eight years since the Committee's investigation into abuses in the sale of insurance to the elderly. The purpose of this report is to determine the status of the Medicare program in America today, both in terms of its future solvency and its current benefit structure; to identify Medicare's shortcomings and gaps in coverage; to examine the role of private insurance in supplementing Medicare's coverage gaps; to evaluate the effectiveness of the States in regulating the sale of Medicare supplemental insurance; and lastly, to determine whether State and Federal regulatory agencies have done an effective job in eliminating the abusive marketing practices identified in earlier Congressional investigations. Ultimately, the questions this report seeks to answer are: "How effective has the 1980 reform legislation been in bringing about a reduction in abuse in the sale of supplemental insurance to the elderly? Do abuses persist?"

The answers to these questions are immensely important as the Congress and the Administration in coming months will be developing legislative proposals to insure Medicare's future solvency and improve its benefit package. As we look to the means for protecting Americans against bankrupting health catastrophes like Alzheimer's and many forms of cancer -- not covered by public or private insurance -- we must scrutinize the adequacy and effectiveness of health insurance coverage currently available to our nation's older Americans.

In the course of conducting this inquiry, the Subcommittee staff undertook the following steps:

- At the Chairman's request, prepared and sent to all State Commissioners of Insurance a detailed 11-page questionnaire designed to ascertain each State's experience in the regulation of Medicare supplemental insurance. Results from this February 1984 questionnaire have been tabulated and appear in Section V of this report. The questionnaire itself is reprinted in its entirety in Appendix A of this report.

- At the Chairman's request, prepared and sent to all State Commissioners of Insurance a 6-page questionnaire to update each State's experience in the regulation of Medicare supplemental insurance. Results from this March 1986 questionnaire have been tabulated and appear in Section V of this report. The questionnaire itself is reprinted in its entirety in Appendix B of this report.

- Conducted detailed followup telephone interviews with all State Departments of Insurance in 1983 and 1986.

- Reviewed all hearings and reports on this subject by Congressional committees and administrative agencies.

- Reviewed all books, periodicals, and newspaper articles relating to Medicare supplemental insurance policies in the possession of the Library of Congress.

- At the Chairman's request, prepared and sent to 647 Area Agencies on Aging a 26-item questionnaire designed to measure the knowledge older people have about the basic attributes of health insurance. Each AAA was to administer the questionnaire to one senior center within their geographic reach, with no fewer than 20 senior citizen respondents. The results of this questionnaire were tabulated and appear in Section II of this report. The questionnaire itself is reprinted in its entirety in Appendix C of this report.

- Recruited postal inspectors to assist the Subcommittee staff as detailees in identifying fraudulent practices in the sale of insurance to supplement Medicare.

- Asked every Congressional office to save complaints received with respect to the operation of Medicare and private insurance for the month of July 1984. Literally hundreds of complaints were received from a quarter of all Congressional offices. The complaints were analyzed and summarized in part and appear in Section II of this report.

- In order to determine firsthand if abuses in the sale of Medigap insurance policies are as frequent and widespread as this report suggests, the Subcommittee staff interviewed a dozen insurance agents in Maryland, Virginia and the District of Columbia. A senior citizen recruited by the Subcommittee to serve as an interested insurance consumer was present at every sales presentation. In addition, a senior citizen recruited for the 1978 investigation was once again assigned to assist the Subcommittee. The sales presentations were meant to test whether agents would engage in abusive sales techniques to make a sale. The senior citizen volunteers already had supplemental insurance. One was adequately insured, the other was overinsured. The results of the Subcommittee's investigation is detailed in Section IV of this report.

- Discussed Medigap insurance abuses with participants in senior citizen centers in Maryland, Virginia, the District of Columbia, and Louisiana to ascertain their familiarity with their insurance coverage and its gaps. Our analysis of their perceptions are detailed in Section II of this report.

- Requested expert analysis of insurance advertisements and literature received by the Subcommittee during the course of its inquiry. Solicitations were reviewed by experts with nationally recognized medical or scientific expertise in the specific line of insurance the ad was said to address.

- Called upon the General Accounting Office (GAO) to undertake a review of all Medicare supplemental insurance policies promoted to cover the gaps in long-term care. This inquiry is a recent request and currently in progress. Therefore the results are not available for public distribution.

In 1978, the Committee found that one dollar out of every $4 spent on supplemental health insurance by the elderly was wasted -- for a total of $1 billion. The Subcommittee estimates that senior citizens will be taken for more than $3 billion in 1986, and that the amount of dollars lost will continue to escalate until corrective action is adopted.

Section I of this report documents the dramatic increase in the cost of health care since the enactment of the Medicare program. In 1950, Americans spent $12 billion for health care. By the end of 1986, our nation's annual expenditures for health will have increased a startling 3,535 percent to $424 billion, or an average of $1,723 per person. Expenditures for health care are expected to continue to grow rapidly, more than doubling by the year 2000 to over a staggering $1 trillion.

Increased health care costs impact disproportionately on older Americans who continue to be sick three times as often and three times as long as their under-65 counterparts. The elderly will pay nearly three times as much as younger adults for health care. In 1966, the year that Medicare went into effect, older Americans paid an average of $445 per capita for health care. In 1986, per capita expenditures for health care among the aged will average $4,601. In sum, elderly will pay 1/3 of the nation's health care bill in 1986 totalling $131 billion.

The Medicare program has been a godsend to our nation's 28 million elderly. Today, the program pays about 48 percent of the average older American's health costs. But in order to offset the ever escalating portion of the health bill not covered by the Medicare program, seniors are increasingly purchasing private health insurance to supplement their Medicare coverage. Today, four of five senior citizens have insurance to supplement Medicare, often referred to as "Medigap" insurance. (About 10% of these senior citizens receive supplementation through the Medicaid program.) Most have at least one such policy, many have more. This represents a 6 percent increase over 1978 -- the year the House Select Committee on Aging determined that about two-thirds of the elderly were in possession of Medigap policies. In all, the 21 million elderly who in 1986 own Medigap policies will pay an estimated cost of $13 billion, or more than $600 per person on the average. In return, private insurance will pay about 7 percent of the aged's health care bill, in contrast to Americans under the age of 65 who will pay about $112.4 billion for private health insurance and have approximately 86 percent of their health care bills paid for by private insurance.

In 1972, Blue Cross and Blue Shield provided 50.1 percent of all Medicare supplemental policies; independent plans accounted for 4 percent and commercial insurance companies received a 45.9 percent share of the Medigap marketplace. These figures have changed little over the last 13 years. Blue Cross garnered 45 percent of the Medigap market in 1985, followed by commercial insurance companies and other prepaid plans capturing about 55 percent.

As in 1978, the Subcommittee found few problems associated with the sale of Medigap insurance by Blue Cross/Blue Shield or other companies selling group insurance to the elderly. The primary problems still relate to the operation of companies who specialize in the sale of Medigap insurance to the elderly on an individual basis.

Section II of the Report discusses the benefits of the Medicare program, what it covers and what it does not cover. From the beginning of the Medicare program, there remains a misunderstanding about the extent of Medicare's coverage. Partly, the result of wishful thinking and partly the result of the distribution of misleading publications which trumpeted Medicare's virtues, senior citizens have been left with the impression that Medicare offers comprehensive coverage. In the years following Medicare's enactment, millions of senior citizens have had their illusions rudely shattered having been left with sizeable bills which Medicare refuses to pay.

Escalating health care costs have resulted in older Americans actually paying more of their incomes for doctors, hospitals, drugs and long-term care than they did before Medicare was enacted in 1965. Other factors fueling increased health costs borne by elders include the implementation of the new prospective payment system for hospitals in 1983, resulting in a reduction in the number of days a senior citizen will stay in a hospital. This coupled with fewer doctors willing to accept what Medicare offers as full payment (7 out of 10 doctors "accepted assignment" in 1966, as compared to less than 1 out of 3 today), have both left seniors with a larger portion of their hospital and doctor's bills for which Medicare will not reimburse them.

Coupled with the aged's increased share of the health care bill for services "covered" by Medicare is the financial burden associated with services "not covered" by the Medicare program, including out-of-hospital prescription drugs; eyeglasses and eye care; dentures and dental care; hearing aids and hearing care; custodial nursing home care; most food care; immunizations; and home care services, except under increasingly limited circumstances.

Section III notes that seniors, fearful of potential bankruptcy and loss of financial independence associated with a long, drawn out illness, are increasingly turning to the purchase of private insurance to supplement Medicare. Seventy percent have at least one such policy, many have three, four or more, mistakenly thinking that more is better. Section III describes the types of policies sold in supplementation of Medicare and the marketing methods most commonly used by the health insurance industry. The Subcommittee found that the potential benefit from Medigap coverage has declined substantially since 1981, due largely to the imposition of the Medicare prospective payment system which has resulted in shorter hospital stays. Under the new system, older Americans are sent home sooner and for the most part "Medigap" policies stop paying when one leaves the hospital.

The Subcommittee also found that the televion is competing effectively with the salesmen as a marketing tool in the sale of insurance to older Americans. Well known personalities are extremely effective, the Subcommittee discovered, in inducing thousands of seniors to buy the Medigap policy they endorse. Unfortunately, few elderly understand what Medicare or their private insurance covers, and therefore, are quite receptive to plans offered or promoted by well-known and trusted television personalities. The simple fact is that no policy covers all of Medicare's gaps, and few Americans, including the elderly, understand that fact. A 1986 survey by the Subcommittee administered by the Area Agency on Aging directors to over 8,000 senior citizens nationwide underscored this sad truth. Nearly 80 percent of all seniors surveyed in 1980 believed that Medicare would pay for nursing home care should they need it -- when in fact, 90 percent of nursing home care is rendered in custodial facilities which are not covered by Medicare or private insurance for the most part. The 1986 survey results reaffirmed this 1980 finding.

Section IV of the Report reaffirms the 1978 Committee finding that older Americans are frequently the targets of fraud and abuse in the sale of Medicare supplemental insurance; that such abuses are not isolated but occur nationwide, and that the incidence of abuse has not diminished but persists in spite of regulatory improvements at the State level. Section IV provides a chronology of Federal, State, local and private efforts relating to abuses in the sale of Medicare supplemental insurance to the elderly; an analysis of responses from State Commissioners of Insurance

confirming abuses in the sale of Medicare supplemental insurance to the elderly from 1978 to 1986; and a summary of investigations of the House Select Committee on Aging and its Subcommittee on Health and Long-Term Care confirming abuses in the sale of Medicare supplemental insurance to the elderly from 1978 to present day.

Who is responsible for regulating the health insurance industry and what has been done about curbing the increasing incidence of abuse in the sale of such insurance to the elderly? In part, the answer is that the States still retain near-exclusive authority to regulate the insurance industry since the Congress enacted the McCarran-Fergusson Act in 1945, stating essentially that no Act of Congress, unless specifically relating to the business of insurance, shall be construed to "invalidate, impair, or supercede" any State laws regulating the business of insurance.

If the primary responsibility for regulating the sale of insurance rests with the Staes, the logical question Section V of the Report seeks to answer is, "How effective have the States been in their regulation of health insurance and more specifically of Medicare supplemental policies?" To determine the effectiveness of the States in monitoring abuses inthe sale of Medigap insurance to the elderly, comprehensive questionnaires were prepared and sent by the Subcommittee to all 50 State Departments of Insurance in 1984, and again in 1986. The questionnaires sought answers to questions regarding the State's budget and staff resources for insurance regulation, the dollar volume for all premiums paid for all kinds of insurance sold in their States, State laws in place to protect the public from misrepresentations in the sale of insurance, the number of agents licensed to sell health insurance in each State, agent licensing requirements, disciplinary actions taken against agents and/or companies when it was determined that abuse did in fact occur, health insurance complaints received annually, the types of abuses brought to the attention of each State Department of Insurance, and their views on further regulatory reform necessary or desirable. The responses to these questionnaires were tabulated, analyzed and presented in Section V of the Report.

Section VI seeks to determine the effectiveness of those Federal agencies with regulatory authority relating to the sale of health insurance in the United States. This section reports on the activities and regulatory authority of the United States Postal Service, the Federal Trade Commission, the Department of Health and Human Services and the Justice Department in this regard.

Section VII provides the summary and conclusions of the Subcommittee's investigation into abuses in the sale of health insurance supplementing Medicare, and Section VII provides policy recommendations that might be considered by State and Federal lawmakers.

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VII. SUMMARY AND CONCLUSIONS

It has been almost 8 years since the release of a landmark report by the House Select Committee on Aging which documented for the first time the broad scope of abuses in the sale of insurance to supplement Medicare. It has been more than 6 years since the passage of reform legislation designed to diminish the incidence of such abuse. The purpose of this report was to determine whether abuses persist, and what impact, if any, the reform legislation has had in curbing the abuses we uncovered in 1978.

The findings of this report come at a time when the Congress and the Administration are looking for ways to remedy the anticipated solvency problems facing the Medicare program and to improve the protection its seniors receive. As we look for the means of protecting Americans against bankrupting health catastrophes like Alzheimer's disease and many forms of cancer -- not covered by public or private insurance -- we must scrutinize the adequacy and effectiveness of health insurance currently available to our nation's senior citizens.

The Medicare program has been a rich blessing for seniors and literally no one would suggest that we give it up. But the dramatic increase in the cost of health care -- almost 3600% since Medicare's enactment in 1965 -- has ripped giant holes in the fixed incomes of older Americans. Many of these people experience great difficulty trying to meet rising health care costs. Escalating costs have resulted in older Americans paying more of their incomes for doctors, hospitals, drugs and long-term care than they did before Medicare was created in 1965.

Coupled with the aged American's increasing health care bill are costs associated with numerous costly services, like dental, eye and hearing care, out-of-hospital prescription drugs, custodial nurisng and home care, and foot care, which are not covered by the Medicare program or most private insurance.

For the many older Americans who will do anything rather than go on welfare, the purchase of health insurance supplementary to Medicare seems to be the only answer. It is wisdom which leads 21 million elderly today to buy one comprehensive policy, but it is fear that motivates many of them to buy more. The Subcommittee found that the potential benefit from Medigap coverage has declined substantially since 1981, due largely to the imposition of the Medicare prospective payment system which has resulted in shorter hospital stays. Under the new system, older Americans are sent home sooner and for the most part "Medigap" policies stop paying when one leaves the hospital.

Unfortunately, seniors have, for the most part, a misunderstanding of Medicare and of Medicare supplemental insurance, and the extent of either one's coverage. They don't realize that if they buy more than one policy to supplement Medicare, only one will probably pay. (Policies contain a clause, generally, that states that only one policy will cover the claim.) On the other hand, nearly 90 percent of the 9,000 seniors surveyed by the Subcommittee felt that Medicare or their supplemental policy would pay for custodial nursing care if required. The fact of the matter is that they don't, and what they do cover -- hospital care -- is a diminishing benefit, as mentioned above.

The simple fact is that no policy covers all of Medicare's gaps. Our 1986 study also confirmed the finding that few seniors understand that reality either.

The Subcommittee found that seniors continue to fear the loss of independence and the onset of bankruptcy should an illness strike. If anything, their fear is heightened today due to increased awareness regarding rising medical costs. Absent aggressive regulatory and enforcement action, they remain as vulnerable today as they were in 1978 to exploitation in their search for health security.

Abuses persist in an unprecedented fashion when it comes to the sale of insurance in supplementation of Medicare. The abuses are not isolated but occur nationwide. The only difference between 1978 and today is the amount of money seniors waste for insurance ripoffs. In 1978, the Subcommittee found that one out of every four dolalrs spent for Medigap insurance by the elderly is wasted. Today, $3 billion is wasted annually by older Americans.

The Subcommittee found that there were few problems presented by the insurance held under Blue Cross or the reputable commercial companies doing group business -- which account for about $7.8 billion of the $13 billion to be spent by older Americans in 1986 on Medigap insurance. The problem remains with the $5.2 billion in Medigap policies purchased on an individual basis. The fact is that elderly will get back only about 60 percent of the money they invest in such policies in the form of claims. Adding back a factor for duplication and low loss ratio experienced in some dread disease and indemnity policies, which are not required to meet the 60 percent loss ratio requirements

the majority of States have adopted, the Subcommittee estimates that senior citizens are being taken for $3 billion a year and that, absent corrective action, this figure is unlikely to decrease.

The Subcommittee found that even though the States hae done a good job in implementing regulatory improvements in the Medigap insurance marketplace, they have been relatively ineffective in curbing abuses. A review of the new regulations since the 1978 investigation reveals that most States do not possess the necessary enforcement authority to require compliance.

To say that Federal agencies with enforcement and regulatory authority over the sale of health insurance have done a poor job since 1978 would be an understatement about their performance. The Department of Health and Human Services, for example, is responsible for implementing and overseeing the voluntary certification program and criminal penalties established by the Baucus/Pepper legislation passed in 1980. They were required to transmit to the Congress two major reports of State approaches to regulating Medigap insurnace. In addition, they were required to report on the effectiveness of the voluntary certification program and criminal penalties established by the 1980 law. The Department, to date, has failed to comply with either requirement. In additon, the Department of HHS has identified only 4 cases involving alleged violations of these criminal provisions and have not taken formal action on any. Not one Medigap policy, to date, has been Federally certified. Four have been submitted for review.

The Federal Trade Commission is responsible for the oversight of activities relating to the protection of Americans against deceptive trade and sales practices in the Medigap marketplace. Although FTC's authority is somewhat limited under Federal law, the Subcommittee found that the FTC has stopped ongoing consumer protection relating to Medigap insurance.

The Department of Justice has responsibility for prosecuting cases on behalf of the Federal government involving violations of the criminal provisions of the 1980 reform legislation. To this date, their involvement has been virtually nonexistent. Since 1981, the Department has been involved in 3 Medigap-related actions. One resulted in an indictment. None has resulted in a conviction. The Inspector General of teh Department of Health and Human Services shares similar investigative activities as the Department of Justice in this regard. Similarly, the IG has been inactive in this area.

The United States Postal Service has responsibility for investigating and bringing actions against those found in violation of the wire or mail fraud statutes involving the sale of Medigap insurance. Although limited in its authority, it is currently the only agency which has made an active, ongoing effort, since 1980, to combat abuses in the sale of Medigap insurance. They have had great success in assisting the States in uncovering and prosecuting insurance scams around the country.

The Subcommittee concludes that the 1980 reform legislation and State regulatory improvement in the last 6 years have been of little value because they are not enforced. The States and the Federal government are not doing an adequate job of protecting senior citizens against unscrupulous agents who would seek to take advantage of them. This fact is particularly serious in view of the near unanimous conclusion from the States that abuses persist. The elderly today are no better off than they were in 1978. They are still seeking to purchase hope, health and security and are left with empty pockets and further disillusionment. That these practices have gone unchecked for the past 8 years is a national scandal of only slightly lesser magnitude than the schemes of the agents who perpetrate the insurance abuse.

VIII. POLICY RECOMMENDATIONS

It has been almost eight years since the House Select Committee on Aging made a nubmer of legislative and regulatory recommendations toward remedying abuses identified in the sale of Medicare supplemental insurance to the elderly. Unfortunately, very little meaningful progress has been made at the Federal level. Progress has been made at the State level, but much still remains to be done to provide older Americans the protection they need and deserve.

As this report documents, abuses in the sale of insurance in supplementation of Medicare persist. Furthermore, confusion is rampant among the elderly over what Medicare pays and how they can best protect themselves against its "gaps." Most of what the Federal agencies have done to protect senior citizens from confusion and abuse over Medigap insurance can be characterized as bumbling and ineffective at best. There has essentially been an abdication of Federal regulatory responsibility.

Congress placed great faith in the ability of the Department of Health and Human Services and the Federal Trade Commission to work vigorously toward ensuring older Americans the protection required to end the widespread abuse identified by the Committee in the late 1970's.

Department of Health and Human Services (HHS)

The Department of Health and Human Services, acting principally through the Health Care Financing Administration (HCFA), has been woefully remiss in its implementation and administration of the Baucus/Pepper Medigap reform legislation enacted by Congress in 1980. It must immediately take a number of steps to adequately execute its duties.

RECOMMENDATION: HHS should immediately transmit to the Congress the report of the comprehensive study and evaluation of State approaches to the regulation of Medigap. This report under the mandate of Federal law was to be delivered January 1, 1982.

RECOMMENDATION: HHS should immediately transmit to the Congress all due back reports on the effectiveness of the voluntary certification system and penalties provisions established in 1980 under Baucus/Pepper.

RECOMMENDATION: HHS should, on an annual basis, rigorously review the regulatory programs of all States to ascertain their relation to the Federal minimum standards.

RECOMMENDATION: HHS should rigorously pursue reported cases of Medigap abuse and pursue the criminal penalties established under Baucus/Pepper against the perpetrators of Medigap abuse. The Office of the Inspector General within HHS should undertake proactive efforts in this regard.

Federal Trade Commission (FTC)

Although the FTC outlined an ambitious program in 1978, this Federal agency has ended an substantive involvement in protecting older Americans from deceptive practices in the sale and marketing of Medigap insurance.

RECOMMENDATION: The FTC must aggressively seek out and investigate Medigap abuses allowed to persist even in the presence of State law. It is especially important for the FTC to assert its authority under the law to protect consumers in the interstate sale and marketing of Medigap.

U.S. Department of Justice

The Department of Justice has not been aggressive in working to combat Medigap abuse.

RECOMMENDATION: The Justice Department, through U.S. Attorneys around the nation, must vigorously seek out and prosecute perpetrators of the abusive acts outlawed in the Baucus/Pepper Amendments.

U.S. Postal Service

The U.S. Postal Service, through its Postal Inspection Service, is the only Federal agency which has effectively pursued fraud and abuse in the sale of Medigap insurance. It is ironic that this agency, with very limited association with Medigap regulation, has been able to crack down on those who use the mails to deceive the eldelry, while the agencies with primary responsibility have done little.

RECOMMENDATION: Congress should consider legislation similar to H.R. 4213, which would stiffen the penalties for violations of the mail and wire fraud statutes to $10,000 fines per offense and jail sentences of up to 10 years. The Federal government should also be given the authority to recoup monies and other assets garnered through these abusive and deceptive acts.

The States

In the past decade, while little progress has been demonstrated by the Federal

government, we have been pleased to note that useful activity has taken place at the State level. In States where vigorous leadership and enlightened legislative and political support exists, many significant improvements have been made. Even in States which have not been as active, enactment of model standards put forth by the National Association of Insurance Commissioners has had positive effects.

Unfortunately, as our surveys and investigations have demonstrated, the gap remains wide between State legislation adn State regulation and enforcement. Furthermore, the educational efforts put forth by States, while commendable, have not borne the results intended. More importantly, several significant areas of abuse are generally not covered under State laws. In addition, many States do not impose adequate standards on indemnity and dread disease Medigap insurance policies.

RECOMMENDATION: All States should require mandatory loss ratios of not less than 60 percent for hospital and long-term care indemnity policies and dread disease policies.

RECOMMENDATION: Each State Insurance Commissioner should collect and make available to the public a complete listing of loss ratios for each insurance company and each Medigap policy in force in the State.

RECOMMENDATION: Each State should establish minimum education, training and moral fitness requirements for insurance agents. States should consdier requiring agents to post a bond or enacting legislation making an insurance agent a fiduciary with a duty to sell only the insurance suited to each individual's needs. A fiduciary duty could be imposed on agents and combined with a self-enforcing mechanism such as voidability at the buyer's option and a private right of action.

RECOMMENDATION: States should seek to regulate the amount of commissions paid to agents. Attempts could be made to equalize commissions for new policies and more renewals. The present gap between 65 percent commissions for new policies and 10 percent on renewals is unacceptable. The payment of commissions in excess of 100 percent of the first year's premium are unconscionable and should be prohibited. Any commission over 50 percent of annual premiums charges should be deemed excessive.

RECOMMENDATION: States should establish counseling offices or toll-free hotlines to aid senior citizens with questions about their insurance needs.

RECOMMENDATION: States could increase the number of investigators and auditors in their State Departments of Insurance and equip them with the requisite computer capability to: (a) respond to consumer complaints; (b) initiate periodic investigations into the practices of various companies and/or their agents; (c) determine if data filed with the Department of Insurance is accurate; (d) evaluate requests for premium increases; (e) conduct financial audits of the resources, assets and practices of insurance companies on a periodic basis; (f) identify fraud, misrepresentation or other deceptive practices in the field of insurance.

RECOMMENDATION: States should require that every company that sells insurance in the State supply the name and address of the policy holder, the kind of policy coverage and the dollar amount of premiums to the State Insurance Commission in a form compatible with computer facilities in the possession of the State Department of Insurance, to facilitate a computer analysis for duplicate billings and overlapping coverage.

The Congress

There are many possible temporary or patchwork responses to the many problems posed by Medicare supplemental insurance identified in this repaqt. While these proposals would improve the protection against abuse and deception afforded older Americans, none get at the root cause of these problems -- the inadequacy of the

Medicare benefit and payment structure. There is a pressing need for comprehensive Medicare reform to provide for full coverage of Medicare's "gaps." This is the only way to truly solve the Medigap crisis we face today.

RECOMMENDATION: The Congress should consider legislation (such as H.R. 4287) to establish a new Part "C" of Medicare which would eliminate Medicare's major gaps. This new voluntary Part "C" would eliminate all current copayments and deductibles for Parts A and B of Medicare. It should also provide coverage for vital preventive services such as eye care, dental care, hearing care and preventive physician visits. A third fundemental component of such a new Part "C" should be comprehensive long-term care coverage for chronically ill Medicare beneficiaries. This coverage should be geared towards the environment of least restriction. This new voluntary Part "C" program would rely on a public/private partnership, taking the best of efficiencies and innovations for private enterprise and the best from the Federal government in safeguarding the quality and level of services provided beneficiaries.

Mr. PEPPER. Thank you everyone that has helped us today.
The subcommittee is adjourned.
[Whereupon, at 1:50 p.m., the hearing was adjourned.]

APPENDIX

PREPARED STATEMENT OF PETER J. FERRARA, SHAW, PITTMAN, POTTS & TOWBRIDGE, WASHINGTON, DC

Some offer horror stories of fraudulent insurance agents selling duplicative or misrepresented health insurance policies to the elderly. While there have been abuses, the industry overall is professional and responsible. About half of all private Medicare supplemental policies are sold by Blue Cross and Blue Shield organizations, which everyone admits are not involved in any fraudulent conduct. Another 30% approximately is sold through the elderly organizations themselves such as AARP and NCSC. Most of the coverage for the remaining 20% of the market is sold by some of the nation's largest, most respected and established insurance companies, or provided by HMOs or by former employers through group insurance, all of whom cannot be validly accused of fraudulent conduct. The abuses which do exist are clearly limited to a very small part of the market.

Actions have been taken to curb these abuses. The industry has established professional bodies which train and certify agents. Since 1980 the states, with encouragement from the Federal government and the insurance industry, have adopted comprehensive schemes of regulation which have helped to stop fraudulent practices. In a recent survey, only 6 of the nation's state insurance commissioners indicated that they might need additional regulatory tools to address problems in the sale of health insurance to the elderly.1/ The National Association of Insurance Commissioners recently disbanded its committee on regulations for the sale of private Medicare supplement policies, concluding that no further changes in those regulations were necessary.

One can find instances of fraud and misrepresentation in every market. We all hear stories from time to time about doctors performing unnecessary operations or overcharging Medicare or Medicaid. But such instances of fraud do not mean that private medicine is a "rip-off" which should be taken over by the government. Similarly, we all hear stories of fraudulent nursing home operators, but that doesn't mean the government should take over operation of nursing homes. Indeed, if every industry where fraud can be found were to be shifted to the public sector, our

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1/ See the report cited in footnote 2.

private economy would be virtually abolished. This could hardly be expected to eliminate fraud, however, because such activity is well-known in the public sector as well.

Nevertheless, hearings recently held by the Subcommittee on Health and Long-Term Care of the House Select Committee on Aging, along with an accompanying report, clearly indicate an attempt to bootstrap allegations of fraudulent sales practices into a pretext precisely for a government takeover of the private Medicare supplemental insurance industry.2/ The hearings and the report were aimed primarily at supporting a proposal for a new Part C of Medicare intended to supplant the private Medicare supplemental policies. Both the hearings and the report were thoroughly and brazenly one-sided, and shot through with faulty analysis and erroneous statements.

The apparent crusade evidenced by the hearing and the report is unfortunate, because it distracts attention from the many constructive policy alternatives which could receive bipartisan support and substantially improve health coverage and care for the elderly. Many of the report's own recommended regulatory improvements to address deceptive sales practices may be quite sound and desirable and could also receive bipartisan and industry support. All the major insurers selling Medicare supplemental policies to the elderly want to see the deceptive sales practices ended, because these major insurers lose business to the fraudulent operators, and often have to bear extra costs due to the manipulative practices of some disreputable agents.

The Subcommittee hearing, held on June 26, 1986, featured 4 elderly witnesses each of whom clearly had become quite angry upon discovering that neither Medicare nor their private supplemental policies covered necessary long term care in a nursing home for an elderly member of their family. As a result, each family had to bear tens of thousands of dollars in nursing home expenses. Yet, the insurers selling the vast majority of Medicare supplemental policies as discussed above do not claim that these policies cover long term care, and the witnesses offered no evidence suggesting that they had been told their policies would cover such care. In fact, the Medicare supplemen-

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2/ Catastrophic Health Insurance: The "Medigap" Crisis, Hearings Before the Subcommittee on Health and Long-Term Care of the Select Committee on Aging, U.S. House of Representatives, Ninety-Ninth Congress, Second Session, June 25, 1986; Catastrophic Health Insurance: The "Medigap" Crisis, A Report by the Chairman of the Subcommittee on Health and Long-Term Care of the Select Committee on Aging, U.S. House of Representatives, June 1986 (hereinafter "Hearing Report").

tal insurers are required by law to state in the policy summary outline and in the policy language, as well as in a "buyers guide" accompanying each policy, that long term care is not covered.

The fact that these elderly individuals did not recognize that they were not covered for long term care is probably due more to the extravagant claims made by politicians and government officials on behalf of Medicare, than anything the private insurers have done. Surveys by AARP have found that 80% of the elderly erroneously believe that long term nursing home care is covered by Medicare. Indeed, few in Congress would support including long term care coverage in a Medicare Part C plan replacing the private Medicare supplemental policies, because to do so would be too expensive. Private insurers are now developing and starting to offer insurance for long term care, and policy options to encourage this development and to promote private sector financing for such policies are discussed above.

The report itself did offer some legitimate examples of individual instances of abuses and deceptive practices. But these legitimate examples were overwhelmed by an incredible litany of unfounded, unsupported assertions and statements, wild exaggerations, repeated inaccuracies, out of context quotes, fundamental misconceptions, outdated data and charges, rehashed stories, quotations of unverified statements which are often erroneous, and other literary and intellectual miscarriages. The report almost never documents any statistic by citation to an authoritative source. The report is long on adjectives and adverbs characterizing the supposed extent of the sales abuses, but it offers no quantification of such abuses, except in one instance, where the quantification is completely fallacious and wildly erroneous, as discussed below. Such a report does not aid public discussion and understanding of the issues.

Both the hearing and the report reflect a basic lack of understanding of the fundamentals regarding the private catastrophic health insurance supplementing Medicare. In both, discussion of this insurance was jumbled up with discussion of hospital indemnity insurance, which provides a certain amount of cash for each day of hospitalization, and insurance for specific diseases such as cancer. But these indemnity and specific disease policies are sold to young and old and have nothing to do with Medicare. These policies do not meet the legal definition and requirements for Medicare supplemental policies and are not among

the insurance products which have been advanced as adequately performing the function of providing catastrophic protection to the elderly for acute care. Mixing up discussion of these extraneous policies with discussion of the Medicare supplemental policies is consequently inappropriate, and simply confuses the issue. It allows criticism and charges which apply to these policies to tar the Medicare supplemental policies which are truly performing the catastrophic role for acute care for the elderly.

The report states over and over ad nauseum that an elderly customer who buys more than one health insurance policy can only collect under one. This is not true, and if the authors of the report don't know this they had no business drafting a report on this subject. The Medicare supplemental policies generally pay in full regardless of how many policies the customer owns. The whole idea behind the hospital indemnity policies, which the report considers, is to pay additional cash above what regular health insurance policies will pay.

The report's whole discussion of duplicative coverage and the purchase of multiple policies was consequently completely confused and uninformed. Many policies that the report considers are designed to be purchased as supplements to other policies. This is the case with the hospital indemnity policies, which are indeed complementary to standard Medicare supplemental insurance or to the standard group health insurance covering unretired workers. These policies are intended to provide additional cash for non-medical expenses incidental to hospitalization, for medical expenses related to such hospitalization which may not be covered by regular health insurance, and to replace lost income due to such hospitalization. Moreover, if specific disease policies such as cancer policies are to make any sense at all, they must be purchased as supplements to standard basic health insurance policies, such as Medicare supplemental policies for the elderly. Specific disease policies cannot be sensibly purchased alone because they only cover one or a few specific diseases, such as cancer. Consequently, it should not be considered unreasonable or a shocking revelation for an elderly person to have a basic Medicare supplemental policy, a hospital indemnity policy and a cancer policy, or for a salesman to attempt to sell a combination of them.

Moreover, elderly customers sometimes buy more than one basic Medicare supplemental policy as a way of covering extra

medical costs not covered by Medicare or a single supplemental policy. The elderly do this in particular to cover the excess fees above the Medicare approved fees charged by doctors not "on assignment" under Medicare. As noted above, most of the private Medicare supplemental policies are based on Medicare approved charges. For example, coverage for the 20% Part B co-insurance fee is usually for 20% of the Medicare approved fee. If the doctor charges more than this approved fee, no portion of the excess is covered, by Medicare or the private policy. With 3 private supplemental policies, however, the customer will receive from the policies alone payment for 60% of Medicare approved charges under Part B, resulting from payment of 20% under each policy for the 20% Part B co-insurance fee. If the Medicare approved fee is only 70% of what the doctor charges, for example, then Medicare will pay only 56% of such charges (80% x 70%). But the three policies will each pay an additional 14% of the total charges (20% x 70%), altogether totaling 42% (3x14%) which, when added to the 56% paid by Medicare, will just about compensate the customer completely for the costs.

Of course, with the purchase of too many such policies, the purchaser is more than covering potential liability, and is in effect investing in the possibility of his own extreme illness. The purchase of multiple basic supplemental policies also may not be the best means of covering the potential liability because the coverage is not fitted to the actual risk the purchaser faces. Medicare supplemental policies are offered which directly cover the extra fees and costs above Medicare approved charges, and this is a superior way to cover the risk. The major insurers themselves do not favor the purchase of several Medicare supplemental policies by a single individual or family because this skews their own risk away from the assumed pattern on which their policies are based. It also creates a "moral hazard", where the purchaser may have an incentive to become hospitalized or treated by a doctor because of the multiple payoff for his costs which would result from ownership of several policies.

There are instances where individual customers have gone way over board, perhaps at the behest of an unscruplous agent, and purchased far too many policies, to the detriment of the customer and/or the insurance companies involved. But there really is no evidence of any widespread purchase of multiple policies beyond packages of compatible policies or calculated attempts as discussed above to cover otherwise uncovered expenses through the

purchase of 1 or 2 extra Medicare supplemental policies.

The report's discussion of loss ratios, which represent the percentage of premiums paid out in benefits for each policy, is also grossly inadequate. The report repeatedly fails to recognize that by law Medicare supplemental policies are required to have at least a 60% loss ratio. Moreover, it can be demonstrated that about 90% of the elderly with Medicare supplemental policies are covered by policies with average loss ratios of 80% to 90%. Blue Cross and Blue Shield companies have average loss ratios around 85% or more, and these policies cover 50% of the market as noted above. Group coverage provided by former employers and the coverage provided by HMOs performs even better than this, accounting for at least another 10 to 15 percent of the market. Elderly groups accounting for another 25% to 30% of the market have recently raised the loss ratios on their policies to 80%. Most of the remainder of the market offers loss ratios around 70%.

There was much complaining in the hearing and the report about famous media stars and personalities promoting the private Medicare supplemental policies on television. But beyond vague grumbling, no one has adequately defined what the problem with these "TV pitchmen", as they were called in the hearing, is supposed to be. No one has identified any specific misrepresentations or false statements made in particular commercials by particular media stars. If such a misrepresentation or false statement is identified, then a complaint to the sponsoring company by approporiate goverment officials will surely be sufficient to get it corrected.

These commercials are actually of the same general quality and rectitude as all other TV commercials, with which consumers have great experience. The grumbling and complaining about them is fundamentally misguided. The media personalities are frankly performing a public service by effectively expanding catastrophic health care coverage to more of the elderly. Thoughtful government officials should be seeking to encourage them to continue to do so.

Charges were made at the hearing and in the report that it was somehow misleading for insurers to state correctly in their advertising that their policies paid the Medicare co-insurance fees for the 61st to 90th days of hospital care and the lifetime reserve days, because there is a low probability that any elderly individual will be in a hospital for that many days and the

coverage is consequently somehow worthless. But this contention reflects a fundamental lack of understanding of how insurance works. Insurance generally covers events with a relatively low probability of occurring in the case of any one individual. It is that low probabiltiy that makes the pooling of the risks involved in insurance beneficial. Young adults have a quite low probability of dying, but that doesn't mean life insurance for them is worthless. Similarly, any individual house has a low probabilty of burning down, but that doesn't make fire insurance worthless. There is in fact a low probabilty that any particular elderly individual will have truly catastrophic medical costs in any year, but that doesn't make catastrophic health insurance worthless. Moreover, the Medicare supplemental policies cover much more than just these co-insurance fees, including the more frequently incurred first day hospitalization deductible, now $492 and rising to $572 next year, and the Part B co-insurance fee equal to 20% of expenses. This was not mentioned in the context of the above charges at the hearing or in the report.

Another fallacy stated repeatedly in the report is the suggestion that because the length of the average hospital stay under Medicare has declined since 1981, due to adoption of the Medicare Prospective Payment System,3/ the value of the private Medicare supplemental policies for the elderly has declined substantially. In fact, the opposite is true. The decline in the average hospital stay has caused the indexed Part A deductible for the first day of hospitalization to rise rapidly, reaching $492 this year and scheduled to jump to $572 next year. The reudced average hospital stay has also been accompanied by an increase in hospital reentries causing the first day deductible to be incurred a second time. The co-insurance fees for extended hospitalization past 60 days are tied to the increase in the first day deductible, and therefore have increased rapidly as well. Moreover, it is not true that payment under the private supplemental policies usually stops when hospitalization is over, as the report repeatedly states. The private policies cover the 20% Part B co-insurance fee, additional skilled nursing facility

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3/ Under the prospective payment system, the government sets the fee it will pay for hospital treatment of each illness based on average market costs. If treatment costs more than this, the hospital cannot collect from the patient and must absorb the costs. If treatment costs less, the hospital can pocket the difference. This system gives hospitals a tremendous incentive to reduce the length of hospital stays, and it has had the effect of doing so.

care, and often other services Medicare does not cover. These costs can continue to be substantial even after hospitalization is over. The reduction in hospital stays may well have caused an increase in these other costs. The continued rapid use in medical costs has also surely increased the cost of the Part B 20% co-insurance fee. Since the private Medicare supplemental policies cover all these items, they have become more valuable.

It should also be recognized that since so few elderly experience extended hospitalization past 60 days, the recent decline in the frequency of such extended periods of hospitalzation has itself had little impact on the cost and value of the private supplemental policies. The big cost for such policies is due to the first day hospitalization deductible and the 20% Part B co-insurance fee, both of which have been increasing substantially. To the extent the reduced long-term hospitalization has reduced costs for the private policies, these reduced costs are reflected in the premiums, making them less than they would be otherwise.

Even much of the discussion of individual instances of sales abuses identified in the report absurdly attacks individual agents or insurers for practices that could hardly be considered abusive, but rather simply involve typical and routine salesmanship seen in all sectors of our economy, and with which consumers have much experience. Lawrence Welk is criticized for telling elderly viewers in a TV commercial that the Medicare supplemental policy of Mutual of Omaha provides "protection everyone over 64 should have."4/ But this is exactly true, and the government should frankly be trying to promote this message. An insurance agent is criticized for correctly telling a prospective customer that the first day hospitalization deductible under Medicare shot up last year from $400 to $492, and would likely continue climbing, suggesting the value in insuring against it.5/ The same agent is criticized for saying, "Insurance buys you peace of mind. Even if you're feeling fine today, you may not tomorrow", and for stating correctly that payment could be made, "annually, semi-annually, quarterly, or monthly, and with any major credit card."6/ For shame!

4/ Hearing Report, page 45.

5/ Hearing Report, page 46.

6/ Hearing report, page 78.

Another agent is criticized for telling the story of a woman who was uninsured, became hospitalized and had to use the family's life savings on health bills, and then telling his customer "I know you don't want to find yourself in a situation like that."7/ Agents are criticized for trying to sell customers a Medicare supplemental policy and a hospital indemnity policy with the suggestion that the policies are complementary, which is true, a fact the report's "investigators" apparently did not understand. Agents are criticized for quoting rates on a weekly basis and for just dropping by to visit potential customers, "all the while intending to sell more insurance." Other agents are criticized for using cartoon pictures in their sales presentations to emphasize valid points.

The report often repeats specific charges in certain instances when it is clear that the "investigators" made no attempt to verify the facts or allegations, or to get the other side of the story. In other instances, it is not clear that the report's "investigators" really understood what was going on and whether a real abuse was taking place, such as whether an agent tried to sell truly duplicative policies.

In many instances, the report's authors do document broad exaggerations, misleading claims and illogical double talk by agents. But the report's authors engage in similar exaggerations, misleading claims and illogical double talk on virtually every page of the report. Indeed, one wonders to what extent the same "abuses" can be found in the fund raising letters and campaign speeches of most politicians.

Most egregious of all is the one attempt in the report to quantify the extent of any abuse - the estimate that the elderly lose $3 billion each year due to waste, fraud and abuse in the sale of the private Medicare supplemental policies. Digging into the report to find the basis for this figure reveals that it has no legitimate foundation whatsoever, and frankly is not a responsible contribution to the public debate.

The figure is calculated by estimating that about $13 billion will be paid by the elderly this year in premiums for private catastrophic policies supplementing Medicare, with about $7.8 billion for insurance from Blue Cross and Blue Shield and

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7/ Hearing report, page 78.

the "reputable commercial companies doing group business", and about $5.2 billion for policies purchased on an individual basis. The report finds little problem with the sale of insurance from Blue Cross or the group insurance. Of the $5.2 billion paid for individual insurance, the report states that only 60% will be returned to the elderly in benefits, and assumes that the rest, about $2 billion, must be due to waste. It then adds in an additional sum based on "a factor" to account for the sale of multiple, duplicative policies to the same buyer, and a further amount involving an estimate to account for policies covering specific diseases and for indemnity policies where allegedly less than 60% of premiums are paid in benefits, reaching a total final estimate of $3 billion.

The big fault in this analysis is the assumption that all premium dollars not returned in benefits represent a wasteful "rip-off". Such analysis includes in waste the taxes paid by the insurers, the costs for sales, marketing and administration, and all the other necessary and legitimate costs of doing business. It is patently absurd to refer to these costs as waste. The report offers no basis for finding that any of the costs besides payment of benefit claims were not necessary and legitimate. Moreover, as discussed above, about 90% of the elderly with Medicare supplemental policies are covered by policies averaging loss ratios of 80% to 90%. Since the law requires a minimum of 60% for the catastrophic policies supplementing Medicare, the report lamely assumes the policies would pay no more than that. But competition has forced the percentage higher.

In addition, as discussed above, indemnity policies and policies for specific diseases such as cancer should not be mixed up with an evaluation of the private Medicare supplemental policies which are providing catastrophic protection to the elderly for acute care. Also, the report offers no basis for its "factor" estimating losses due to the sale of multiple, duplicative policies to the same customer. Indeed, as we have noted, the report is based on the erroneous assumption that the customer who buys multiple policies can only collect under one, whereas the truth is the customer usually can collect in full under each such policy he purchases. So while the purchase of multiple policies may sometimes be inadvisable, one cannot simply assume it is a total waste in each case. The report, therefore, simply offers no sound basis for finding any specific dollar

amount of waste in the sale of the Medicare supplemental catastrophic policies.

There is no denying that the report did include many valid renditions of individual instances of outright, unacceptable, abuse and fraud by sales agents. And there is no reason to deny it because the dishonest activity hurts the major carriers and honest agents themselves. The honest players lose business to the dishonest actors who are not playing by the rules. Moreover, many of the abuses are costly for the insurers. For example, agents who convince elderly customers to replace perfectly good policies with equivalent ones to get the higher commissions on the new sales are causing the insurance companies to pay unnecessary commissions. Agents who overload elderly customers with too many policies are exposing the insurers to unplanned risks. Companies must often refund premiums and they along with the entire industry suffer bad publicity due to abuses by a few agents. The major insurers and the vast majority of agents, who are honest professionals, would like to see greater efforts to enforce the existing laws so that those who engage in such conduct will be properly punished. They would also support desirable regulatory changes which might further reduce the improper and abusive conduct.

It is, therefore, quite ironic and sad that so much time was spent in the hearing and the report bitterly assailing the private insurers, with the aim of justifying a government takeover of the private industry, particularly while the body of the report included many recommended regulatory reforms which could be beneficial and receive broad support. These promising regulatory proposals include:

> (1) Each State Insurance Commissioner should collect and make available to the public a complete listing of loss ratios for each insurance company and each Medigap policy sold in the state.
>
> (2) States should establish counseling offices or toll-free hotlines to aid senior citizens with questions about their insurance needs.
>
> (3) States could increase the number of investigators and auditors in their State Departments of Insurance and equip them with the requisite computer ability to: (a) respond to consumer complaints; (b) initiate periodic investigations into the practices of various companies and/or their agents; (c) determine if data filed with the Department of Insurance is accurate; (d) evaluate requests for premium increases; (e) conduct financial audits of the resources, assets and practices of insurance companies on a periodic basis; (f) identify fraud, misrepresentation or other deceptive practices in the field of insurance.

(4) States should require that every company that sells insurance in the State supply the name and address of the policy holder, the kind of policy coverage and the dollar amount of premiums to the State Insurance Commission in a form compatible with computer facilities in the possession of the State Department of Insurance, to facilitate a computer analysis for duplicate billings and overlapping coverage.

(5) Each state should establish minimum education, training and moral fitness requirements for insurance agents.

With monitoring of policy sales by computer in particular, the states could drastically curtail the problem of purchases of multiple policies. Each state could put an outright limit on multiple purchases.

Another possible regulatory change would involve modification of the minimum standards for Medicare supplemental policies under the Baucus Amendment. As discussed above, these minimum standards require every policy to include an entire range of specified, basic coverage. As also discussed above, the elderly sometimes buy more than one such policy to attempt to cover in particular the excess fees charged by doctors above Medicare approved fees, which are not covered by Medicare or a single supplemental policy alone. The Baucus standards could be modified to allow policies which just cover these excess fees and are sold only as supplements to customers who have the basic catastrophic coverage. This would eliminate the primary reason the elderly sometimes buy duplicative Medicare supplemental policies today.

The Federal government and state governments should also do much more to inform the elderly about what Medicare does not cover, particularly long term nursing home care. The states should run TV ads advising the elderly that they should buy one good standard Medicare supplemental policy and one of the new long term care policies now coming on the market, to cover the gaps in Medicare. The ads could refer the elderly to a state consumer affairs office which would maintain an approved list of policies that satisfy these concerns, as well as a list of appropriate supplemental policies to meet excess charges from doctors not on assignment under Medicare.

Any new regulations must be carefully crafted to avoid imposing counterproductive, impractical burdens on the insurers and sales agents. Such burdens could discourage insurers and agents from aggressively marketing and promoting health coverage to the elderly, ultimately reducing the degree of such coverage and leaving the elderly in many instances without access to essential

health care. For example, requiring agents to post bonds as the report suggests would place a new costly burden on agents with little practical benefit for the elderly. Subjecting agents to further standards of fiduciary duty to customers might expose the agents to numerous, frivolous, unwarranted lawsuits. Reducing commissions for new sales might leave agents insufficiently compensated for the costs of such new sales.

The abuses which do exist in the sale of the supplemental Medicare policies can be eradicated without imposing impractical burdens on the industry and agents. The Massachusetts Commissioner of Insurance testified at the hearing that regulation in his state had virtually eliminated the problem.8/ Out of 73,000 complaints and telephone inquiries received by the state regarding insurance coverage, only about 100 related to the private Medicare supplemental insurance, and most of these involved complaints concerning delays in benefit payments. As discussed above, state insurance commissioners generally now believe they have the regulatory tools to address the abuses in the sale of these policies. With the adoption of a sound system of regulation and convincing display of vigorous enforcement, those few malefactors who are perpetrating the abuses will likely leave the field.

We should not lose perspective on the real magnitude and nature of the problem, and its persistance in every facet of human endeavor, in the public and private sectors. The abuses which do exist are clearly limited to a small portion of the market, and regulatory efforts have already proven capable of sharply reducing them, and even virtually eliminating them in at least some places. Innovative reforms to address the problem further have been proposed. These reforms can be pursued in a bipartisan fashion with industry support. But we must first recognize that there clearly is no sound basis for a government takeover of the private Medicare supplemental insurance industry.

8/ Testimony of Peter Hiam, Massachusetts Commissioner of Insurance, Before the House Select Committee on Aging Subcommittee on Health and Long-Term Care, June 25, 1986.

PREPARED STATEMENT OF WILLIAM L. ROPER, M.D., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Mr. Chariman and members of the Committee I would like to thank you for the opportunity to discuss the experiences of the Health Care Financing Administration with respect to administering and monitoring the Supplemental Health Insurance Program. As you know, we supported enactment of the 'Medigap' Legislation and share your concern about the abuses it was intended to alleviate.

Background

In response to widespread allegations in regard to the marketing and content of Medicare supplement insurance policies, Congress enacted the so-called "Medigap" legislation as part of the Social Security Disability Amendments of 1980 (Public Law 96-265) in June 1980. The legislation established federal standards for Medicare supplement coverage in order to encourage States to intensify their regulation of these policies. Specifically the legislation:

- o established a Supplemental Health Insurance Panel to review State Medicare supplemental insurance regulations for compliance with the Federal standards;
- o established a Federal Voluntary Certification Program to allow display of a Federal seal of approval for Medicare supplement policies in States where the Panel did not approve their regulatory program;
- o established Federal criminal penalties for violation of Medicare supplement marketing provisions; and,
- o required the Secretary of Health and Human Services to study the effectiveness of the various State Regulatory Programs and criminal penalities and make recommendations on the results found.

The Medigap legislation was carefully drafted to reduce Federal involvement in the business of insurance which has traditionally been a State responsibility as affirmed in the McCarron-Ferguson Act of 1945. The legislation has involved cooperative effort between State and Federal agencies to assure the best protection for our elderly citizens.

Legislative Implementation

- o State Regulatory Programs

After passage of the legislation, the Health Care Financing Administration (HCFA) moved to allocate staff to this new responsibility and appoint a Supplemental Health Insurance Panel. The Panel, composed of four State Insurance Commissioners and a designee of the Secretary of Health and Human Services, began the task of reviewing State Medicare supplementary insurance regulatory programs. In response to this review, a vast majority of the States promulgated regulations in compliance with the Federal standards. These standards, which were based on the 1979

National Association of Insurance Commissioners (NAIC) model regulation, require:

- certain coverage requirements
- full disclosure
- limitation on pre-existing condition clauses
- cancellation provisions
- and minimum loss ratios

At the present time, 46 States and the District of Columbia with regulatory programs have been approved by the Supplemental Health Insurance Panel. Four States (Massachusetts, New York, Rhode Island and Wyoming) have not been approved by the Panel because of technical differences with the NAIC model regulation. Although these four States have not been approved by the Panel, they all closely regulate Medicare supplemental insurance policies to protect senior citizens in their jurisdictions.

The Panel continues, on a periodic basis, to review any changes in State regulatory programs for compliance with the Federal minimum standards. To date, the approved States have not altered their programs and remain in compliance.

o Voluntary Certification Program

Because the vast majority of States have approved regulatory programs, the Voluntary Certification Program has never been utilized. Only two policies have been submitted for certification. When additional information was requested of the insurers, the companies choose not to re-submit the policies for certification.

Although the Voluntary Certification Program has not been utilized, we believe it has accomplished its objective of increasing State regulation of this important area of insurance. The program has provided States with an incentive to regulate these policies more diligently and has not required direct Federal involvement.

o Penalty Provisions

The Health Care Financing Administration, serves as coordinator for investigations and possible violations of Medigap penalty provisions. The system of coordination for reporting these violations includes the ten HCFA regional offices, the Social Security Administration (SSA), the Office of the Inspector General (OIG) for the Department of Health and Human Services, and the Department of Justice (DOJ).

The initial screening of complaints is generally done through HCFA's regional offices. These offices are also responsible for furnishing information to State insurance departments about specific complaints.

The OIG is responsible for investigating complaints that have been referred to them by HCFA and coordinating this activity with State insurance departments. The OIG also serves as the liaison between State insurance departments and the U.S. Attorneys, who have been contacted by the Fraud Division of DOJ regarding the Medigap Law and encouraged to prosecute violations of this section.

HCFA has been informed of 43 possible violations of the penalty provisions. Twenty of these involved allegations of persons falsely representing an association with the Medicare program or any Federal agency for the purpose of selling or attempting to sell health insurance. Two cases involved allegations of knowingly selling duplicative health insurance to an individual entitled to Medicare, where such a policy will not pay duplicate benefits. Of the complaints received: five have been investigated by specific State insurance departments, fifteen were closed due to lack of evidence, and two have been investigated by the OIG. One case investigated by the OIG and the FBI resulted in an indictment but subsequent acquittal of three insurance agents in Pennsylvania in September 1982. The other twenty-one have also been closed. Of these cases, fifteen were closed by State insurance departments after referral for lack of evidence, and six resulted in State administrative sanctions.

HCFA also receives many complaints which, while we have been advised by the OIG are not in violation of the Medigap law, are possible violations of other federal statutes. These most often involve misleading advertising and mail order solicitations for Medicare supplemental insurance. HCFA routinely forwards these cases to State insurance departments, the Federal Trade Commission and the Postal Inspection Service for potential prosecution

Research

The legislation also calls for the Secretary to conduct several studies on the effectiveness of the various State approaches to the regulation of Medicare supplemental policies. In order to determine the extent of the problems of concern to Congress and to classify the types of State regulations, we gathered information on State insurance regulations, and conducted consumer and industry surveys in 6 selected States (California, Florida, Missouri, New Jersey, Washington, and Wisconsin). These 6 States reflected a spectrum of regulatory approaches.

The issues of marketing and agent abuses, informed choice, adequate insurance products in the private market place and duplicative coverage were looked at during in the consumer survey which was conducted in 1982. We then, in 1983, conducted an industry survey to get at the issue of reasonable economic benefits and price competition. Some preliminary findings indicate:

- Minimum benefit standards for Medicare supplements are substantially widespread and uniform with respect to minimum standards as required under the Medigap legislation.

- That consumer knowledge about Medicare benefits was higher concerning services commonly used; such as physician office visits, than about services less frequently used, such as hospital and nursing homes.

- The two most common abuses reported were pressure exerted to buy a policy and agent claims that the policy would pay for everything Medicare did not cover.

We have prepared a report to Congress of our study findings with recommendations on the need for additional standards for Medicare supplemental policies. This report will be sent to Congress soon.

Catastrophic Care

Furthermore, we are looking at ways of providing the best Medicare health coverage for all of our elderly citizens. As chairman of the 1982 Advisory Council on Social Security, Dr. Bowen recognized the coverage problems faced by the elderly and recommended that the Medicare program be restructured in order to provide adequate protection to them in the event of catastrophic illnesses. Since taking the helm of Health and Human Services, Dr. Bowen has established a Task Force to study this issue and fulfill the Presidential mandate given to him in The State of the Union message to recommend how the private sector and government can work together to address the problems of those with catastrophic health care costs. This study will be completed by the year's end and will contain an assessment of Medigap's role in containing out-of-pocket liability of our beneficiaries.

Conclusion

We believe implementation of the Medigap legislation has substantially reduced the abusive practices associated with the sale of Medicare supplemental insurance. The Medigap law has increased public awareness of these problems and encouraged States to more closely regulate these insurance policies.

In terms of consumer awareness, we have developed jointly with the National Association of Insurance Commissioners an informational pamphlet entitled Guide to Health Insurance For People With Medicare. The pamphlet contains a brief description of Medicare coverage and exclusions, an explanation of the types of private health insurance available to senior citizens, and some helpful hints on evaluating and purchasing Medigap insurance. The pamphlet is available through Social Security District Offices, the Health Care Financing Administration regional offices as well as by mail from central office. All Social Security recipients have been alerted via direct mailing, of the availability of the information pamphlet. Over 10.5 million copies of the guide have been distributed to date.

In addition, the Administration on Aging has a substantial nationwide network of senior citizen groups which has served as the foundation for a Medigap training program. In broad outline, AOA recruits the volunteer trainers and coordinates their instructional activities while HCFA regional offices provides technical training on Medicare. Responses to date of senior citizen organizations to this volunteer training opportunity have been most encouraging. So far, over 800 training sessions have been held in every State, with more than 40,000 people participating.

We will continue our efforts to improve and to ensure the success of the Medigap program and to continue the availability of appropriate Medicare supplement insurance to our beneficiaries.

211 CMR 47.00.
RULES AND REGULATIONS GOVERNING INDIVIDUAL ACCIDENT AND SICKNESS INSURANCE

Section

47.01. Purpose
47.02. Applicability and scope
47.03. Effective date and implementation
47.04. Definitions
47.05. Readability standards
47.06. Standards for policy definitions
47.07. Minimum standards for coverages
47.08. Required disclosure provisions
47.09. Policy and rate filings and review
47.10 to 47.89. Reserved
47.90. Appendix A - Medicare Supplement 1
47.91. Appendix B - Medicare Supplement 2
47.92. Appendix C - Medicare Supplement 3
47.93. Appendix D - Medicare Supplement Comparisons
47.94. Severability

§47.01. Purpose.

This regulation is designed to provide reasonable standardization and simplification of the terms, coverages, organization, and format of individual accident and sickness insurance policies and of subscriber contracts of non-profit hospital, medical, and dental service corporations in order to facilitate public understanding and comparison. The regulation is meant to ensure that policies are written in an easily understood manner; to provide for full disclosure of policy contents; to eliminate provisions which may be misleading or unreasonably confusing in connection with either the purchase of coverage or the settlement of claims; to prevent the sale of "Medicare Supplement" coverage which does not in fact complement Medicare; to establish standards by which to judge the reasonableness of benefits in relation to premiums; and to minimize deceptive sales practices.

§47.02. Applicability and scope.

This regulation shall apply to all individual accident and sickness insurance policies and to non-group subscriber contracts of non-profit hospital, medical, and dental service corporations filed with the Division of Insurance, delivered,

STATUTORY AUTHORITY: M.G.L. Chap. 175, §§ 2B, 108 and 110E; Chap. 176, § 26; Chaps. 176A, 176B, 176E

Added, 1980-1

or issued for delivery after the effective dates of this regulation, except group conversion policies or contracts. Health Maintenance Organizations are exempted from 211 CMR 47.07 and following. No policy or contract covered by this regulation shall be issued or issued for delivery unless it complies with this regulation. This regulation supplements the rules of 211 CMR 40.00 through 42.00; in case of direct conflict between this and earlier regulations, this regulation shall govern.

§47.03. Effective date and implementation.

This regulation shall take effect upon publication in the Massachusetts Register, except that the provisions of 211 CMR 47.08(1), 47.08(2)(a) and 47.08(2)(b) shall take effect on the date that the requirements of M.G.L., c. 175, s. 2B, as amended by c. 222 of the Acts of 1979, apply to a policy.

§47.04. Definitions.

1. *Insurer* includes hospital, medical, and dental service corporations; *Insurance* includes plans run by such corporations; *Insured* includes subscribers to such plans; *Policy* includes subscriber contracts of such corporations; and *Individual Policies* include those issued other than to groups by such corporations.

2. *Pre-existing condition* means a covered person's medical condition which caused that person either

(a) to have received medical advice or treatment for the condition during the twelve month period prior to the effective date of coverage or

(b) during that time to have had symptoms which would have led an ordinarily prudent person to seek medical advice or treatment for that condition.

§47.05. Readability standards.

The text of all policy forms not exempted under M.G.L. c. 175, s. 2B, must meet the requirements of that section, including a minimum Flesch readability score of 50. All forms should be written in clear and understandable English. When possible, technical terms must be avoided.

The text of all riders and endorsements to be used with such policy forms should separately achieve a Flesch score of fifty or higher. If such a form fails to meet this standard, an explanation must be given of why this standard cannot be met and the certification made pursuant to 211 CMR 47.09(1)(o) of this regulation must indicate that such form, in conjunction with any other

form or combinations of forms to which it will be attached will achieve a score of fifty or higher.

§47.06. Standards for policy definitions.

1. Limitations on benefits, such as policy exclusions or waiting periods, should where possible be so labeled in a separate section of the policy or placed with the benefit provisions to which they apply, rather than or in addition to being included in other sections of the policy, such as the definitions section.

2. To promote clarity and readability, definitions of disability should make clear the time, if any, for which an insured must be disabled, whether by being unable to engage in his or her own occupation, in others, for which he or she is qualified by education, training, and experience, or otherwise. Definitions should avoid hard-to-understand expressions like inability to perform "each and every" or "any and every" duty of an insured's occupation.

§47.07. Minimum standards for coverages.

Nothing in this section shall be construed to require insurers to provide greater mental health or alcoholism benefits than are mandated by statute. Nor shall this section be construed to prevent nonprofit hospital and medical service corporations from basing payment on allowances rather than on charges or limiting benefits to those received from providers with whom they have an agreement, or such providers and other providers which are qualified and have agreed to provide services under Medicare, as long as such limitations do not significantly reduce the availability of benefits under the policy.

(1) *Specified Disease Coverage.*

(a) "Specified disease coverage" has a maximum benefit limit of no less than $10,000 and provides benefits for all of the following specifically named or described conditions:

1. Cancer in any of its manifestations.

2. Severe extensive disabling burns and contractures due to burns.

3. Disabling paralysis of extremities due to inflammation, degeneration, or other benign lesion of the central nervous system.

4. Disabling major bone fractures, bone fusions, joint dislocations, joint fusions, and limb amputations.

5. Acute infraction of the heart and chronic disabling congestive heart failure.

6. Chronic ulcerative colitis and chronic regional enteritis.

7. Chronic tuberculosis and chronic osteomyelitis.

8. Chronic rheumatoid arthritis, chronic rheumatic fever, chronic chorea, chronic disseminated lupus erythematosus, chronic periarteritis, or other chronic collagen or systemic sensitivity.

9. Addison's disease, pituitary disorders, or other major endocrinopathies, but not including diabetes.

10. Chronic severe or totally disabling pulmonary insufficiency.

11. Chronic hemolytic anemia, chronic aplastic anemia, chronic toxic anemia, and other chronic bleeding disorders requiring continuing therapy, but not including iron deficiency or blood loss anemia.

12. Chronic nephrosis, chronic nephritis, and cystic fibrosis.

The conditions must be verified conclusively by biopsy, x-ray examinations, laboratory determinations or if an external defect, by unequivocal observation.

(b) Internal limits on dollar benefits can be no less than the following:

1. Room and board daily benefits in semi-private accommodations of at least $150 per day or charges, whichever is the lower, for at least 60 days of continuous hospital confinement.

2. All other scheduled benefits must provide a benefit maximum of at least 10% of the total aggregate maximum benefits.

(c) Specified Disease Coverage shall be guaranteed renewable, as defined in 211 CMR 47.09(4)(c), to age 65 or to the date a person on Social Security disability, or age 65, is insured under Medicare A and B, and a Massachusetts Medicare Supplement Policy. Specified Disease Coverage may not be sold to anyone over age 65.

(d) Specified Disease Coverage may be sold only as a supplement to Basic Hospital Insurance as defined in 211 CMR 42.07. The benefits shall begin when the coverage in the Basic policy is exhausted.

(e) Any policy covering specified diseases must meet the standards of 211 CMR 47.07(1)(a) through 47.07(1)(d); it may not be sold as Restricted Health Insurance as defined in 211 CMR 42.13.

(2) Medicare Supplement Insurance. "Medicare Supplement Insurance" is coverage designed primarily to complement Medicare Parts A and B or is

advertised, marketed, or otherwise purported to complement Medicare. It may not be sold to anyone not covered by Medicare Parts A and B and must meet the requirements of the following rules and standards. The following three Medicare Supplement options are mandatory as to standards and benefits and may not be modified in any manner.

(a) Medicare Supplement 1. A Medicare Supplement 1 insurance policy shall provide the coverage specified in 211 CMR 47.90 (Appendix A) and may not provide any additional benefits.

(b) Medicare Supplement 2. A Medicare Supplement 2 insurance policy shall provide the coverage specified in 211 CMR 47.91 (Appendix B) and may not provide any additional benefits.

(c) Medicare Supplement 3. A Medicare Supplement 3 insurance policy shall provide the coverage specified in 211 CMR 47.92 (Appendix C) and may not provide any additional benefits.

Definitions used in a Medicare Supplement Policy shall be compatible with Medicare definitions and practice.

Any Medicare Supplement policy covering the Medicare part A deductible or copayments or the Part B deductible or coinsurance shall provide that benefits will be automatically changed to match any changes in cost sharing, premiums may likewise be changed.

No Medicare Supplement policy shall exclude or limit coverage in any manner inconsistent with the exclusions and limitations of the Medicare program, except that benefits available under Medicare may be excluded.

§47.08. Required disclosure provisions.

(1) *General rules.*

(a) Each category of insurance covered by this regulation shall have a policy summary. Summaries are prescribed by category in 211 CMR 47.08(2). This summary shall not be part of a policy. This policy summary shall be provided to potential policyholders at the time any application for a policy is made. If the policy is issued on such a changed basis a revised summary must be affixed to the policy.

(b) If a policy has a specification page, it shall provide the following information:

1. The policy number;

2. The name of the insured;

3. The other persons covered at date of issue;

4. The effective date, assuming the premium for the policy has been paid on or before that date;

5. A listing of the premium or premiums payable and the periods to which they apply; and except for Medicare Supplement policies;

6. A listing, with cost, if any, of each exclusionary waiver and of each premium-bearing rider or endorsement. Unless the insured has given signed acceptance, the listing shall also include a brief description of each.

(c) If age is to be used as a determining factor for reducing the benefits made available in the policy as originally issued, such fact must be prominently set forth in the policy.

(d) No misleading policy names may be used. An insurer's policy name may not misrepresent the extent of benefits actually provided nor may a name be used which conflicts with the prescribed category name or which is similar to the prescribed name of a different category. In particular, insurers may not use the name "Medigap" or similar term except to describe a policy complying with the Medicare Supplement standards of 211 CMR 47.07(2).

(e) The policy summary must contain the following provision, or one substantially the same, as a separate paragraph: "COMPLAINTS. If you have a complaint, call us at ( )_____ or your agent. If you are not satisfied, you may write or call the Massachusetts Division of Insurance, 100 Cambridge Street, Boston, MA 02202. In Boston call (617) 727-3341. In Springfield call (413) 736-8349."

(f) All summaries for Medicare Supplement insurance must be filed with the Division of Insurance at least twenty (20) days before use, unless the text specified in 211 CMR 47.93 (Appendix D) is used in which case a certified statement, from an officer of the insurer, stating the company is using such comparisons in the exact language of 211 CMR 47.93 (Appendix D) is filed with the Division.

(2) *Disclosure standards by policy category.* Applicants and insureds are to be clearly informed of the basic nature and provisions of policies through a policy summary for each policy, identifying the category to which each policy belongs and summarizing its contents. Policy summaries with identification statements are set out by category below.

(a) Medicare Supplement Insurance. Medicare Supplement policies shall

use the following summary, or one whose language and format are substantially the same.

MASSACHUSETTS MEDICARE SUPPLEMENT POLICY SUMMARIES

(INSURER'S NAME)

(Insurer's Policy Name and Number)

Policy Category: MEDICARE SUPPLEMENT INSURANCE

The Commissioner of Insurance has set standards for the sale of Medicare Supplement Policies. Such policies help you pay hospital and doctor bills, and some other bills, that are not covered in full by Medicare. This policy summary outlines the different coverages you have if, in addition to this policy, you are also covered by Part A (hospital bills, mainly) and Part B (doctors' bills, mainly) of Medicare.

We cannot explain everything here. Massachusetts law requires that personal insurance policies be written in easy-to-read language. So, if you have questions about your coverage not answered here, read your policy. If you still have questions, ask your agent or company. You may also wish to get a copy of "Your Medicare Handbook," a small book put out by Medicare that describes its benefits.

THE BENEFITS TO PREMIUMS RATIO is _____%.

(Insert here the lifetime aggregate anticipated loss ratio from 211 CMR 47.09(3)(b)6.) This means that during the anticipated life of your policy and others just like it, the company expects to pay out $_____ in claims made by you and all other policyholders for every $100 it collects in premiums. The minimum ratio allowed for policies of this type is _____%. A higher ratio is to your advantage.

You have ten days to review this policy. If you decide you don't want to keep it, send it back to the agent or company within ten days of receiving it and you will get a refund of all premiums you have paid. In the case of a direct response (mail order) insurer, you have a 30-day free look.

(Insert here a comparison of the benefits available under Medicare A and B, and for the three Medicare Supplements. If an officer of the company certifies that the company is using the comparison contained in 211 CMR 47.93 (Appendix D), and is in compliance with the remainder of this section,

it will not be necessary for the summary to be submitted to the Division of Insurance.)

(b) Disability Income Insurance. Disability Income Insurance policies shall use the following summary, or one whose language and format are substantially the same. Business Buy-out and Overhead Expense Insurance should use a similar summary appropriate to their policies.

211 CMR 47.00.

MASSACHUSETTS DISABILITY INCOME INSURANCE POLICY SUMMARY

(Insurer's Policy Name and Number)

POLICY CATEGORY: DISABILITY INCOME INSURANCE

(1) READ YOUR POLICY CAREFULLY. This policy summary briefly describes the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail your rights and duties and your insurance company's. You should read your policy carefully.

(2) DISABILITY INCOME PROTECTION COVERAGE. Policies of this category provide coverage for disabilities resulting from accident or sickness. Payments will only be made to covered persons, and some accidents and sicknesses may not be covered. The major benefits and limitations of your policy are listed below. Coverage is not provided for hospital. (Alter last sentence, if such benefits are provided.)

(3) RENEWABILITY OF YOUR POLICY. (Describe policy provisions on renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

(4) BASIC BENEFITS OF YOUR POLICY. (Describe only those of the following benefits which appear in your policy.)

Monthly Benefit for Total Disability. (Use the title of the benefit as it appears in the policy. Briefly describe the benefit, including the amount of the monthly benefit, the maximum period for which the benefit is payable and any elimination or waiting period.)

Definition of Total Disability. (Briefly describe the term as defined in the policy.)

Monthly Benefit for Residual Disability. (Use the title of the benefit as it appears in the policy. Briefly describe the benefit, including the amount of the monthly benefit, the maximum period for which the benefit is payable and any qualification, elimination or waiting period. Also include a statement in effect as follows: "The actual amount of the monthly benefit will be proportionate to the insured's loss of earnings during the period of residual disability.")

Definition of Residual Disability. (Briefly describe the term as defined in the policy.)

Monthly Benefit for Partial Disability. (Use the title of the benefit as it

appears in the policy. Briefly describe the benefit, including the amount of the monthly benefit, the maximum period for which the benefit is payable and any qualification, elimination or waiting period.)

Definition of Partial Disability. (Briefly describe the term as defined in the policy.)

(5) OTHER BENEFITS OF YOUR POLICY. (Give a brief *specific* description of the policy's other benefits which are not optional.)

(6) THE OPTIONAL BENEFITS CHECKED BELOW ARE CONTAINED IN YOUR POLICY: (If the policy form may contain optional benefits selected by the insured, give a brief *specific* description of each such benefit with a space for a checkmark for each.)

(7) EXCEPTIONS, REDUCTIONS AND LIMITATIONS OF YOUR POLICY. (Describe all policy provisions which exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described above. This description should include a brief statement about the treatment of pre-existing conditions.)

(8) FREE LOOK. You have ten days to review this policy. If you decide you don't want to keep it, send it back to the agent or company within ten days of receiving it and you will get a refund of all premiums you have paid. In the case of a direct response insurer (mail order), you have 30 days to review the policy. If you don't want to keep the policy, you may return it to the company within 30 days and get a refund of all premiums paid.

(c) Other Insurance. Any policy which fits within a coverage category established by 211 CMR 42.00 shall use as its policy summary the appropriate disclosure form specified in 211 CMR 42.14 through 42.22. Any submission proposing to use forms other than those specified must explain why they do not vary in any essential way. (See 211 CMR 42.14)

Any Non-Medicare-Supplement policy summary delivered to a person eligible for Medicare shall conspicuously display on its first page the following statement unless the policy does not cover hospital, medical or surgical expenses: "This policy IS NOT A MEDICARE SUPPLEMENT POLICY." The statement may be printed or affixed by sticker.

§47.09. Policy and rate filings and review.

(1) *Policy forms*

(a) All submissions are to be addressed to Massachusetts Division of Insurance, Policy Review Section, 100 Cambridge Street, Boston, MA 02202.

(b) The statutory filing fee shall accompany each form submitted each time it is submitted, whether for preliminary or final review. For submissions under M.G.L. c. 175, the fee is $10.00. Payment shall be by check payable to the COMMONWEALTH OF MASSACHUSETTS, DIVISION OF INSURANCE.

(c) To facilitate prompt replies, insurers shall provide for return communication either by enclosing with each submission a stamped, addressed return envelope of appropriate size or otherwise.

(d) Each form submitted for final approval must be printed, be a printer's proof, or be in the form in which it will be issued.

(e) Any form in which the printed text has been altered will not usually be accepted for final approval.

(f) Each form shall display an identification code not to exceed thirteen spaces on the lower lefthand corner of the first page.

(g) The covering letter shall be submitted in duplicate.

(h) The submission of a rider, application or endorsement shall specify the policy or group of policies with which it will be used. The identification code of such policy or group of policies shall be given together with, if possible, the approximate date of the original filing to expedite review. If a new form makes reference to the provisions of a form previously used that did not require filing or approval, it shall be accompanied by such previous form for reference purposes.

(i) For new policy forms, the number of riders or amendments should be kept to a minimum and periodic updating incorporating changes is expected in order to avoid policy and rider combinations which have a tendency to mislead or confuse the policyholder.

(j) All submitted material shall be filled in with appropriate hypothetical data.

(k) Applications to be attached to policy forms upon issue must be attached to such forms upon submission. If such an application was previously filed and approved or deemed approved, the approximate date of such approval must be noted, if possible. Policy summaries must also be filed with the corresponding policy forms.

(l) The covering letter must state whether the form is new or replaces an approved or previously filed form or forms.

(m) If a form replaces a previously approved or filed form, the identifica-

tion code of the replaced form must be given and differences from the text of the replaced form must be noted. Where an entire form has been rewritten to improve its readability, a general description of changes is sufficient. Substantive changes should be carefully noted.

(n) If a form was previously disapproved, this fact must be set forth in the covering letter with the reasons why the form is resubmitted.

(o) Each submission must include a certification by a company official that each form meets the objective standards of M.G.L. c. 175, s. 2B. The Flesch score for each form must be stated in the certification; a statement to the effect that the score exceeds 50 is not permitted. If an insurer feels that a form is exempt from M.G.L. c. 175, s. 2B, the basis for this contention must be stated in the covering letter.

(2) *Rate manual.* Every insurer shall maintain on file with the Division an up-to-date rate manual for all individual accident and health policies, riders, and endorsements currently available for sale in Massachusetts. Such manual shall include:

(a) name of the insurer on each page;

(b) table of contents or index; and

(c) identification by form number of each policy, rider or endorsement to which the rates apply.

(3) *Rate filings.*

(a) One copy of a rate filing must be submitted with each policy, with each rider, or endorsement that effects the premium rate to be charged, and with all changes in premium rates, whether made by endorsement to a policy, by incorporating into a policy by reference a table of rates on file with the Commissioner, or otherwise. In the case of rate changes, filings shall note the extent of the changes.

Rate filings shall include properly identified rate manual pages, which may be in typed draft or other preliminary form. Policies should not state or imply that the Massachusetts Division of Insurance does not review the reasonableness of rate increases.

(b) Each rate filing shall be accompanied by an actuarial memorandum prepared and certified by a qualified actuary, as defined in the instructions for the Life and Accident and Health Annual Statement Blank. Such memoranda shall contain where appropriate:

1. the formulas or methods used to obtain the gross premiums;

2. a list of all assumptions made in the rate calculations, including identification or mortality, morbidity, and lapse rate tables or experience studies used;

3. the actuarial basis for differential rates by sex;

4. the commission scale applicable to each form and a detailed list of all other anticipated expenses, such as per claim expenses, taxes, underwriting and acquisition expenses, including where possible identification of those expenses which are fixed and those which are variable;

5. the expected claim costs;

6. the anticipated loss ratios for the first 5 policy years, preferably year by year, and for the entire period (the lifetime) for which rates are computed to provide coverage. The anticipated loss ratio during the first 5 years should be calculated on an earned–incurred rather than a written-paid basis. An anticipated loss ratio is defined as the present value at issue of the expected future benefits, excluding dividends, divided by the present value of the expected future annualized premiums. For a given time period, a reasonable interest rate must be used. The aggregate anticipated loss ratios, based on reasonable assumptions as to the distribution of the policy form by age and sex, and by various options available, should also be calculated for each of the above time periods.

The calculations of the expected claims costs and the non-aggregated loss ratios should be clearly described and illustrated, by sex and for representative issue ages, such as 25, 35, 45, 55 and for, where applicable, the average issue age for those age 65 or over. In the case of a policy available with different deductibles, elimination periods, or various other options which can have an effect on the anticipated loss ratio or claims cost, the calculations need be performed for only a typical combination of options.

For loss of income, business buyout and business expense policies, the actuarial memoranda may be limited to the lifetime loss ratios specified in 211 CMR 47.09(3)(b)6., certified as accurate by a qualified actuary; other information under 211 CMR 47.09(3)(b)1. through 47.09(3)(b)6. need not be supplied.

(c) The following standards for maintaining experience data shall apply with respect to individual insurance, to support rate revisions.

1. Maintaining experience. Premium and loss data shall be recorded for each policy form and, where more than one coverage may be provided at the option of the insured under a single policy form, for each major combination

of coverage on the following basis for each calendar year: premiums written or paid; each reserve component; earned premiums; paid losses; and incurred losses.

2. Combining experience. Experience under different policies where the premium and coverage is substantially the same may be combined.

3. Fund accounting. Experience data for policies which are guaranteed renewable but permit the insurer to change the premium shall be maintained on the basis of fund accounts which will reflect premiums, investment income, losses, expenses, and provision for reserves.

(4) *Evaluation standards.* Any rates filed, whether initial or revised, will be disapproved unless the aggregate anticipated loss ratio for the entire period for which rates are computed to provide coverage meets the following standards:

(a) for hospital and medical expense policies (including indemnity policies) and for similar policies the minimum loss ratio shall be:

1. 60% for optionally renewable policies;

2. 55% for conditionally renewable and guaranteed renewable policies; and

3. 50% for guaranteed rate policies.

(b) for loss of income policies the minimum loss ratio shall be:

1. 60% for optionally renewable policies;

2. 55% for conditionally renewable policies;

3. 50% for guaranteed renewable policies; and

4. 45% for guaranteed rate policies.

(c) for purposes of 211 CMR 47.09(4)(a) and 47.09(4)(b) optionally renewable means renewal is at the option of the insurance company; conditionally renewable means renewal can be declined by the insurance company only for stated reasons other than deterioration of health; guaranteed renewable means renewal cannot be declined by the insurance company for any reason, but the insurance company can revise rates on a class basis; and guaranteed rate means renewal cannot be declined nor can rates be revised by the insurance company;

(d) for policies providing either substantially full coverage for specified perils (e.g., auto, common carrier) or short term non-renewable coverage (e.g., trip insurance) the minimum loss ratio shall be 45%;

(e) for policies providing coverage for accidents only the minimum loss ratio shall be 45%;

(f) for policies meeting the requirements of both 211 CMR 47.09(4)(d) and 47.09(4)(e), the minimum loss ratio shall be 45%;

(g) for policies issued to those ages 65 or older the minimum loss ratio shall be 65% for those policies actually held by persons aged 65 or over;

(h) for policies under 211 CMR 47.09(4)(a) or 47.09(4)(b), the minimum loss ratio shall be 5 percentage points less than those given if the expected average annual premium for the policy, including riders and endorsements, is less than $200; and

(i) if, for any policy which provides benefits of substantial economic value to the insured, it can be demonstrated that the minimum loss ratio standards given above cannot possibly be attained, a lower loss ratio is allowable.

(5) *Time provisions.* The following provisions shall apply to individual accident and-health policies subject to M.G.L. c. 175, s. 108. Policies subject to M.G.L. c. 176, 176A, 176B, 176C, and 176E shall be governed thereby.

(a) If a filing has been disapproved and is resubmitted, the cover letter shall note the disapproval and any changes made since the earlier filing, with an explanation of why the new filings should be approved. Resubmission of disapproved forms should, where possible, be made within 90 days of disapproval.

(b) The filer shall have the right to request a hearing within 10 days of receiving a final disapproval. Within 20 days of the receipt of the request, the Division shall schedule a date for the hearing, which must occur within 30 days of the scheduling. At least 10 days written notice of the hearing shall be given to all interested parties.

(c) The hearing officer may order a pre-hearing conference for the resolution or simplification of issues, to be held no less than three days prior to the scheduled date of a hearing.

(d) For a time period of 10 days or less only business days shall be counted. For time periods greater than 10 days, calendar days shall be used.

(47.10 through 47.89: Reserved)

§47.90. Appendix A—Medicare Supplement 1.

A Medicare Supplement 1 Insurance Policy shall provide the following coverage and may not provide any additional benefits:

(1) The following Medicare Part A eligible expenses:

(a) Full semi-private benefits for hospitalization for the first 365 days per benefit period (except that such benefits shall not include charges for blood and shall be limited to the first 120 days in a licensed mental hospital), to the extent not covered by Medicare, less the Medicare Part A deductible;

(b) Services in a skilled nursing facility certified by Medicare during the first 100 days to the extent not covered by Medicare, and $10 per day for the 101st–365th days per benefit period. Benefits for services in all skilled nursing facilities shall be available for a combined maximum of 365 days per benefit period.

(2) Services in a skilled nursing facility not certified by Medicare at $8 per day for 365 days per benefit period, provided the admission otherwise meets Medicare requirements. Benefits for services in all skilled nursing facilities shall be available for combined maximum of 365 days per benefit period.

(3) The following Medicare Part B eligible expense to the extent not covered by Medicare and less the Medicare Part B deductible:

(a) The following outpatient hospital services:

(i) hospital diagnostic services;

(ii) initial visit for emergency treatment within 72 hours of the causative accident;

(iii) initial visit for emergency treatment of sudden and serious illness requiring immediate treatment;

(iv) surgical services;

(v) x-ray therapy and other therapeutic procedures involving isotopes, radium or radon seeds;

(vi) services necessary to continue active treatment which was begun during hospitalization of at least 3 days and which is rendered within 100 days following discharge, excluding treatment of a mental disorder;

(vii) maintenance dialysis.

(b) The following services of physicians, psychologists, podiatrists, and dentists, provided that where Medicare has determined a reasonable charge, such benefits shall not exceed the reasonable charge:

(i) services rendered to the insured while hospitalized during the first 365 days per benefit period, except that such benefits shall be limited to the first 120 days in a licensed mental hospital;

(ii) the following services rendered to an insured who is not hospitalized;

(aa) initial visit for emergency treatment within 72 hours of the causative accident;

(bb) initial visit for emergency treatment of sudden and serious illness requiring immediate treatment;

(cc) surgical services;

(dd) x-ray therapy and other therapeutic procedures involving isotopes, radium or radon seeds;

(ee) Services necessary to continue active treatment which was begun during hospitalization of at least 3 days and which is rendered within 100 days following discharge, except treatment of a mental disorder;

(ff) diagnostic x-ray and laboratory services;

(gg) services rendered in conjunction with maintenance dialysis and self-dialysis training in a hospital or renal dialysis facility;

(hh) dental care that involves surgery of the jaw or related structures, or setting fractures of the jaw or facial bones.

(c) Benefits for maintenance dialysis and self-dialysis training by a renal dialysis facility, and for equipment and supplies provided by such a facility for use in the home.

(d) Services for physiotherapist up to $100 in Medicare allowed charges per year.

(4) Services rendered for treatment of a mental disorder on an out-patient basis, up to $500 per year, less any Medicare payments, as required by c. 1221 of the Acts of 1973 as amended.

(5) Services rendered by a dentist during a Medicare-eligible admission for those services.

(6) Eighty percent (80%) of charges for drugs for which federal law requires a prescription, in excess of twenty-five dollars ($25) per calendar year, excluding drugs for treatment of a mental disorder; or one hundred percent (100%) of charges for generic drugs for which federal law requires a prescription and eighty percent (80%) of

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charges for other drugs for which federal law requires a prescription, in excess of twenty-five dollars ($25) per calendar quarter, excluding drugs for treatment of a mental disorder.

(7) 80% of charges in excess of $100 for services of private duty nurse during hospital admission, up to $300 per benefit period.

(8) For those traveling outside the United States and its territories, coverage for the same services and the same level of payment as is provided within the United States by the combination of Medicare Part A and Part B and the Medicare Supplement 1 Insurance policy.

§47.91. Appendix B — Medicare Supplement 2.

A Medicare Supplement 2 insurance policy shall provide the following coverage and may not provide any additional benefits:

(1) The following Medicare Part A eligible expenses:

(a) Full semi-private benefits for hospitalization (for the first 365 days per benefit include charges for blood and shall be limited to the first 120 days in a licensed mental hospital,) to the extent not covered by Medicare;

(b) Services in a skilled nursing facility certified by Medicare during the first 100 days, to the extent not covered by Medicare, and $10 per day for the 101st - 365th days per benefit period. Benefits for services in all skilled nursing facilities shall be available for a combined maximum of 365 days per benefit period.

(2) Services in a skilled nursing facility not certified by Medicare at $8 per day for 365 days per benefit period, provided the admission otherwise meets Medicare requirements. Benefits for services in all skilled nursing facilities shall be available for a combined maximum of 365 days per benefit period.

(3) The following Medicare Part B eligible expenses, to the extent not covered by Medicare:

(a) The following outpatient hospital services:

(i) hospital diagnostic services;

(ii) initial visit for emergency treatment within 72 hours of the causative accident;

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(iii) initial visit for emergency treatment of sudden and serious illness requiring immediate treatment;

(iv) surgical services;

(v) x-ray therapy and other therapeutic procedures involving isotopes, radium or radon seeds;

(vi) services necessary to continue active treatment which was begun during hospitalization of at least 3 days and which is rendered within 100 days following discharge, excluding treatment of a mental disorder;

(vii) maintenance dialysis.

(b) The following services of physicians, psychologists, podiatrists, and dentists, provided that where Medicare has determined a reasonable charge, such benefits shall not exceed the reasonable charge:

(i) services rendered to the insured while hospitalized during the first 365 days per benefit period, except that such benefits shall be limited to the first 120 days in a licensed mental hospital;

(ii) the following services rendered to an insured who is not hospitalized:

(aa) initial visit for emergency treatment within 72 hours of the causative accident;

(bb) initial visit for emergency treatment of sudden and serious illness requiring immediate treatment;

(cc) surgical services;

(dd) x-ray therapy and other therapeutic procedures involving isotopes, radium or radon seeds;

(ee) services necessary to continue active treatment which was begun during hospitalization of at least 3 days and which is rendered within 100 days following discharge, except treatment of a mental disorder;

(ff) diagnostic x-ray and laboratory services;

(gg) services rendered in conjunction with maintenance dialysis and self-dialysis training in a hospital or renal dialysis facility;

(hh) dental care that involves surgery of the jaw or related structures, or setting fractures of the jaw or facial bones.

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(c) Benefits for maintenance dialysis and self-dialysis training by a renal dialysis facility, and for equipment and supplies provided by such a facility for use in the home.

(d) Services of physiotherapist up to $100 in Medicare allowed charges per year.

(4) Services rendered for treatment of a mental disorder on an out-patient basis, up to $500 per year, less any Medicare payments, as required by c. 1221 of the Acts of 1973 as amended.

(5) Services rendered by a dentist during a Medicare-eligible admission for those services.

(6) For those traveling outside the United States, and its territories, coverage for the same services and the same level of payment as is provided within the United States by the combination of Medicare Part A and Part B and the Medicare Supplement 2 Insurance policy.

§47.92. Appendix C — Medicare Supplement 3.

A Medicare Supplement 3 Insurance policy shall provide the following coverage and may not provide any additional benefits:

(1) The following Medicare Part A eligible expenses:

(a) Full semi-private benefits for hospitalization for the first 365 days per benefit period (except that such benefits shall not include charges for blood and shall be limited to the first 120 days in a licensed mental hospital), to the extent not covered by Medicare;

(b) Services in a skilled nursing facility certified by Medicare during the first 100 days, to the extent not covered by Medicare, and $10 per day for the 101st – 365th days per benefit period. Benefits for services in all skilled nursing facilities shall be available for a combined maximum of 365 days per benefit period.

(2) Services in a skilled nursing facility not certified by Medicare at $8 per day for 365 days per benefit period, provided the admission otherwise meets Medicare requirements. Benefits for services in all skilled nursing facilities shall be available for a combined maximum of 365 days per benefit period.

(3) The following Medicare Part B eligible expenses, to the extent not covered by Medicare:

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(a) The following outpatient hospital services:

(i) hospital diagnostic services;

(ii) initial visit for emergency treatment within 72 hours of the causative accident;

(iii) initial visit for emergency treatment of sudden and serious illness requiring immediate treatment;

(iv) surgical services;

(v) x-ray therapy and other therapeutic procedures involving isotopes, radium or radon seeds;

(vi) services necessary to continue active treatment which was begun during hospitalization of at least 3 days and which is rendered within 100 days following discharge, excluding treatment of a mental disorder;

(vii) maintenance dialysis.

(b) The following services of physicians, psychologists, podiatrists, and dentists, provided that where Medicare has determined a reasonable charge, such benefits shall not exceed the reasonable charge:

(i) services rendered to the insured while hospitalized during the first 365 days per benefit period, except that such benefits shall be limited to the first 120 days in a licensed mental hospital;

(ii) the following services rendered to an insured who is not hospitalized:

(aa) initial visit for emergency treatment within 72 hours of the causative accident;

(bb) initial visit for emergency treatment of sudden and serious illness requiring immediate treatment;

(cc) surgical services;

(dd) x-ray therapy and other therapeutic procedures involving isotopes, radium or radon seeds;

(ee) services necessary to continue active treatment which was begun during hospitalization of at least 3 days and which is rendered within 100 days following discharge, except treatment of a mental disorder;

(ff) diagnostic x-ray and laboratory services;

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(gg) services rendered in conjunction with maintenance dialysis and self-dialysis traning in a hospital or renal dialysis facility;

(hh) dental care that involves surgery of the jaw or related structures, or setting fractures of the jaw or facial bones.

(c) Benefits for maintenance dialysis and self-dialysis training by a renal dialysis facility, and for equipment and supplies provided by such a facility for use in the home.

(d) Services for physiotherapist up to $100 in Medicare allowed charges per year.

(4) Services rendered for treatment of a mental disorder on an out-patient basis, up to $500 per year, less any Medicare payments, as required by c. 1221 of the Acts of 1973 as amended.

(5) Services rendered by a dentist during a Medicare-eligible admission for those services.

(6) Eighty percent (80%) of charges for drugs for which federal law requires a prescription, in excess of twenty-five dollars ($25) per calendar year, excluding drugs for treatment of a mental disorder; or one hundred percent (100%) of charges for generic drugs for which federal law requires a prescription and eighty percent (80%) of charges for other drugs for which federal law requires a prescription, in excess of twenty-five dollars ($25) per calendar quarter, excluding drugs for treatment of a mental disorder.

(7) 80% of charges in excess of $100 for services of private duty nurse during hospital admission, up to $300 per benefit period.

(8) For those traveling outside the United States and its territories, coverage for the same services and the same level of payment as is provided within the United States by the combination of Medicare Part A and Part B and the Medicare Supplement 3 Insurance policy.

§47.93. Appendix D — Medicare Supplement Comparisons.

This section is designed to display the benefits afforded by Medicare Parts A and B, and a comparison of the additional benefits available under the three Massachusetts Medicare Supplements.

Each page is aligned horizontally by type of service so that they may be put together in brochure form. The type size shall be not less than eleven points, two points leaded. The brochure shall also conform with the standards prescribed in 211 CMR 47.08.

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211 CMR 47.00.

APPENDIX D

SERVICE	PARTS A & B OF MEDICARE
Hospital Inpatient - Semiprivate accommodations (2 or more beds in a room)	Full semiprivate charges for the first 60 days after subtracting the $160 Medicare Inpatient deductible in each benefit period.* Then, full semiprivate charges less $40 a day from the 61st through 90th day.
Private Accommodations	Full private room charges after subtracting the amounts indicated above, but only when medically necessary.
Physician or Other Provider Inpatient	80% of Medicare allowed charges after subtracting $60** Medicare calendar year deductible.
Hospital Outpatient Department Clinic, Physician's or Other Provider's Clinic or Patient's Home	80% of Medicare allowed charges for most services (routine physicals, immunizations, eye refractions, etc. are not covered) after subtracting the $60** Medicare calendar deductible.
Outpatient Treatment of a Mental Disorder Hospital Charges for Outpatient Department or Clinic Services	80% of Medicare allowed charges after subtracting the $60** Medicare calendar year deductible.
Physician's Services	Up to a maximum of $250 in a calendar year. However, the maximum payment will be less than $250, if charges for these services are used to meet part or all of the 60** Medicare calendar year deductible.
Skilled Nursing Facilities Participating with Medicare - Patient must have been hospitalized 3 or more days and	Full semiprivate charges for the first 20 days. Then, full semiprivate charges less $20 per day from the 21st to the 100th day.

transferred to the facility within 14 days of hospital discharge.	
Skilled Nursing Facilities NOT participating with Medicare but patient must have been hospitalized 3 or more days and transferred to the facility within 14 days of hospital discharge.	Nothing
Nursing Homes or Rest Homes	Nothing
Inpatient Private Nurses	Nothing
Drugs Used Outside the Hospital Which Require a Prescription	Nothing
Ambulance Service	80% of Medicare allowed charges after subtracting Medicare calendar year deductible for ambulance service to or from a local hospital or skilled nursing facility when Medicare determines that an ambulance was necessary.
Durable Medical Equipment	80% of Medicare allowed charges after subtracting the $60** Medicare calendar Year Deductible.
Services outside of the United States	Nothing, except when the services are rendered in the American Territories, then all Medicare covered services are paid as indicated previously. The Territories are Puerto Rico, Guam, Virgin Islands and American Somoa. Minor exceptions are made during emergencies in border areas

* See Medicare Handbook for Definition of "Benefit Period"
** Only one $60 deductible is applicable each Calendar year.

MEDICARE SUPPLEMENTS

Low Option	Medicare Supplement 1
$40 daily from the 61st through 90th day and full semiprivate charges from the 91st through 365th day of the benefit period* (120 days maximum in a mental hospital).	Same as above, but only up to the average semiprivate charge.
20% allowed charges for Medicare covered physician's or other provider's services during 365 days of inpatient care during each benefit period (120 days maximum in a mental hospital).	
20% of Medicare allowed charges for the following services only: 1. Surgery. 2. First treatment within 3 days of an accident. 3. First treatment of a sudden and serious medical emergency (such as hemorrhage, convulsions, coma). 4. Radiation therapy. 5. Follow-up care within 100 days of a hospital stay of 3 or more days (except for mental disorders). 6. Medicare approved independent physiotherapist's services (combined Medicare & Medex payment minimum of $100 in each calendar year). 7. Most diagnostic x-ray and laboratory services. 8. Podiatrist's services (routine foot care is not covered). 9. Hemodialysis. No benefits for under 65 on Medicare A & B due to Social Security disability.	
The balance of Medicare allowed charges to a maximum of $500 in each calendar year (less any Medicare payments).	
$20 daily from the 21st through 100th day when the patient requires and receives a Medicare covered level of skilled nursing care. Then, $10 daily from the 101st through 365th day as long as the patient continues to require and receive a skilled nursing facility level of care. There are no benefits available beyond the 165th day of the benefit period.	

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$8 a day for up to 365 days when the patient requires and receives a skilled nursing level of care rather than custodial care.

A combined maximum of 365 days in a benefit period is available for Medicare participating and Medicare non-participating skilled nursing facilities.

Nothing

Eighty percent (80%) of charges after subtracting a twenty-five dollar ($25) calendar quarter deductible; or one hundred percent (100%) of generic drug charges and eighty percent (80%) of other drug charges after subtracting a twenty-five dollar ($25) calendar quarter deductible.

80% of charges after subtracting a $25 calendar quarter deductible.

Nothing

Nothing

The same benefits as listed above while traveling outside of the United States including the portion normally paid by Medicare.

---

*You pay the inpatient hospital and the Doctor's deductible under this option 1

Medium Option — Medicare Supplement 2

The $.60 Medicare deductible in each benefit period* $40 daily from the 61st through 90th day, and full semiprivate charges from the 91st through 365th day of the benefit period* (120 days maximum in a mental hospital.)

Same as above, but only up to the average semiprivate charge.

The $60** Medicare deductible and 20% of Medicare allowed charges for Medicare covered physician's or other provider's services during 365 days of inpatient care during each benefit period (120 days maximum in a mental hospital).

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The $60** Medicare deductible and 20% of the balance of Medicare allowed charges for the following services only:

1. Surgery.
2. First treatment within 3 days of an accident.
3. First treatment of a sudden and serious medical emergency (such as hemorrhage, convulsions, coma).
4. Radiation therapy.
5. Follow-up care within 100 days of a hospital stay of 3 or more days (except for mental disorders).
6. Medicare approved independent physiotherapist's services (combined Medicare and supplement payment $100 in each calendar year).
7. Most diagnostic x-ray and laboratory services.
8. Podiatrist's services (routine foot care is not covered).
9. Hemodialysis. No benefits for under 65 on Medicare A & B due to Social Security disability.

The $60** Medicare deductible and balance of Medicare allowed charges up to a maximum of $500 in each calendar year (less any Medicare payments).

$20 daily from the 21st through 100th day when the patient requires and receives a Medicare covered level of skilled nursing care. Then, $10 daily from the 101st through 365th day as long as the patient continues to require and receive a skilled nursing facility level of care. There are no benefits available beyond the 365th day of the benefit period.

$8 a day for up to 365 days when the patient requires and receives a skilled nursing level of care rather than custodial care.

A combined maximum of 365 days in benefit period* is available for Medicare participating and Medicare non-participating skilled nursing facilities.

Nothing

Nothing

Nothing

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Nothing

Nothing

The same benefits as listed above while traveling outside of the United States including the portion normally paid by Medicare.

*See Medicare Handbook for Definition of "Benefit Period".
**Only one $60 deductible is applicable each calendar year.

High Option — Medicare Supplement 3

The $160 Medicare deductible in each benefit period* $40 daily from the 61st through 90th day and full semiprivate charges from the 91st through 365th day of the benefit period* (120 days maximum in a mental hospital).

Same as above, but only up to the average semiprivate charge.

The $60 Medicare deductible and 20% of Medicare allowed charges for Medicare covered physician's or other provider's services during 365 days of inpatient care during each benefit period (120 days maximum in a mental hospital).

The $60** Medicare deductible and 20% of the balance of Medicare allowed charges for the following services only:

1. Surgery.
2. First treatment within 3 days of an accident.
3. First treatment of a sudden and serious medical emergency (such as hemorrhage, convulsions, coma).
4. Radiation therapy.
5. Follow-up care within 100 days of a hospital stay of 3 or more days (except for mental disorders).
6. Medicare approved independent physiotherapist's services (combined Medicare and supplement payment maximum of $100 in each calendar year).
7. Most diagnostic x-ray and laboratory services.
8. Podiatrist's services (routine foot care is not covered).
9. Hemodialysis. No benefits for under 65 on Medicare A & B due to Social Security disability.

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The $60** Medicare deductible and balance of Medicare allowed charges up to a maximum of $500 in each calendar year (less any Medicare payments).
$20 daily from the 21st through 100th day when the patient requires and receives a Medicare covered level of skilled nursing care. Then, $10 daily from the 101st through 365th day as long as the patient continues to require and receive a skilled nursing facility level of care. There are no benefits available beyond the 365th day of the benefit period.*
$8 a day for up to 365 days when the patient requires and receives a skilled nursing level of care rather than custodial care. A combined maximum of 365 days in a benefit period* is available for Medicare participating and Medicare non-participating skilled nursing facilities.
Nothing
80% of customary charges up to $300 per benefit period* after subtracting a $100 deductible.
80% of charges after subtracting a $25 calendar quarter deductible.
Nothing
Nothing
The same benefits as listed above while traveling outside of the United States including the portion normally paid by Medicare.

*See Medicare Handbook for Definition of "Benefit Period".

**Only one $60 deductible is applicable each calendar year.

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§47.94. Severability.

If any section or portion of a section of 211 CMR 47.00, or the applicability thereof to any person or circumstance is held invalid by any Court of competent jurisdiction, the remainder of 211 CMR 47.00, or the applicability thereof to other persons or circumstances, shall not be affected thereby.

STATUTORY AUTHORITY: M.G.L. c. 175, ss. 2B, 108 and 110E; c. 176, s. 26; c. 176A, 176B, 176D.

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A PRELIMINARY RECONNAISSANCE OF LONG-TERM CARE INSURANCE

Report to Commissioner Peter Hiam, Division of Insurance, Commonwealth of Massachusetts

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Introduction

In recent years, a number of commercial insurers and Blue Cross-Blue Shield plans have begun to develop and market policies providing coverage for skilled and intermediate nursing home services and for custodial care delivered in designated facilities and at home. Although the number of long-term care policies now in force is not substantial, future growth in this market appears likely in the light of demographic trends and political and economic tendencies.

In anticipation of this growth, the Division of Insurance commissioned a preliminary reconnaissance of long-term care insurance to provide general background information for the field. The Division asked Consumer Health Advocates, Inc. to gather information on the characteristics of long-term care insurance policies now being marketed; the status of regulatory actions on long-term care products in six selected states; the key features of the long-term care insurance regulatory mechanisms in those states and an overview of the attitudes of key governmental, trade and citizen organizations on the issue of long-term care insurance regulation.

Acknowledgement: The authors wish to thank Dr. Scott Bass of the University of Massachusetts-Boston for his cooperation and advice on this project.

This report has four substantive sections. Section I provides an overview of the long-term care insurance market today. It identifies the companies which have developed or are developing products and summarizes the principal features of policies now being marketed.

Section II describes the regulatory climate for long-term care insurance and provides specific information about the rules applied by six state insurance departments together with the actions taken by those agencies on the products currently being sold. In Section III the activities and positions of various trade associations, membership/consumer groups and government agencies with respect to long-term care insurance regulatory issues are set forth. Section IV sketches some of the regulatory questions that emerge from the preliminary recon-naissance of long-term care insurance markets.

Information appearing in this report comes from four primary sources: telephone interviews with representatives of insurance companies, state insurance departments and consumer/membership groups; insurance policies, rate sheets, descriptive brochures and related materials made available to us by insurers; correspondance with insurers and published and unpublished reports appearing in the long-term care and insurance literature. Since the abstracts and summaries of various insurance policies required some degree of interpretation, reasonable attempts were made to verify the accuracy of the

information provided in this report. The reader should be forewarned, however, that in some instances---particularly those involving hypothetical situations---it was impossible to obtain a definitive statement from the primary information source. While this introduces some amount of ambiguity, we believe that these situations are relatively rare and do not materially affect the tenor of this report.

Finally, we must emphasize that this report is intended as a preliminary description of a rapidly changing marketplace. It is highly selective: for example, it does not deal extensively with such issues as marketing and underwriting although both are clearly important topics that will concern state insurance departments, consumer groups, etc... The report is also intentionally descriptive rather than analytic or prescriptive. The purpose at hand was to gather as much relevant background information as was available in a short amount of time so that follow-up activities could be blocked out. For this reason the report focuses principally on insurance benefits, conditions and premiums.

I. Developments in the market for long-term care insurance.

The long-term care insurance market is in an early stage of development. We have identified fifteen companies now marketing nursing home, custodial and home care insurance

on a non-supplemental basis in one or more of six survey states - Massachusetts, Florida, New York, Washington, Wisconsin and Pennsylvania. In addition, this report identifies three other companies which are reported to be about ready to enter the market with new products. Table 1 identifies these companies and their products (if available) and summarizes the status of their marketing and/or product development efforts.

It is estimated that between fifty to one hundred thousand people are presently insured against the expense of extended long-term care services. With the over-sixty-five population standing at around twenty-eight million at mid-decade, it would be accurate to conclude that private coverage is still a rarity among those at highest risk.

While there has clearly been a degree of interest among insurers in developing products for this fast growing segment of the population, recent market experience has been basically cautious and conservative. The companies have all offered a pretty standard fare of indemnity coverage with some variation in deductibles, and as seen in Table 1, only one company to date---United Equitable---has made a sustained effort to open a national market. For the most part, long-term care policies have been sold by small companies on a regional basis.

Several factors are put forward frequently to explain this reticence. Chronic care requiring convalescent or home-

Table 1. Companies Identified In This Study As Developing Or Marketing Long-Term Care Insurance Policies

Company	Policy Name and Number	Comments
Acceleration Life Ins. Co. Dublin, Ohio	Nursing Home Benefit Policy ANCP520-4(09)	A Florida insurance department report indicates this company has a policy approved. Pennsylvania also has record of approval, but of a different policy number. The business may have been taken over by another company. Efforts to contact Acceleration were unsuccessful.
A.I.G. Life Ins. Company		It was announced at a seminar on long-term care insurance in December that A.I.G. is developing a policy.
American Republic Ins. Co. Des Moines, Iowa	Nursing Home Indemnity Policy A-2655AL	This policy is still in the development stage. It is based on the prototype created by Mark Meiners of the National Center for Health Services Research Principal features include: (1)$100/day for skilled care and for custodial or intermediate care, (2) $50/visit for up to 3 visits per week for home health aid, (3) a limit of 1500 days, (4) a deductible of 20 days for the skilled benefit.
Columbia Life Ins. Company Bloomsburg, PA	Nursing Home Care Policy NHC (683)	The NHC policy is a replacement for an older version (SNH, dating to 1980), which the company discontinued in 1983 because of unacceptable losses. The current policy is more limited and is not available to individuals over age 75. The policy is marketed in 5 scattered states and is not sold in the two states where it has been approved.

Table 1, Cont'd.

Company	Policy Name and Number	Comments
Continental Casualty Co. (CNA) Chicago, Ill.	Skilled Nursing Home Policy PI-52212-A97	The company has been selling this policy since 1974. It is approved in approximately 35 states. Most (70%) of its sales are in 6 states---Washington (30%); Indiana, Michigan, Ohio (30%); New Jersey (10%) and Georgia. Approximately 15,000 policies are currently in force. A new policy will be issued in several months, with: 1,000 days for skilled; coverage for custodial care; deductible periods of 15, 30, or 90 days; and higher premiums.
Equitable Life and Casualty Co. Salt Lake City, Utah	Convalescent Care Policy Form 435	The policy is approved and marketed in 15 Western and Southern states. A special policy had to be developed for Texas.
Federated American Life Ins. Co. Seattle, WA		The company is in receivership. Sterling Life Insurance has taken over its nursing home business.
Fireman's Fund American Life Ins. Company San Rafael, CA	Skilled Nursing Home Benefit Policy, 6318	The company has had a skilled nursing policy since 1976 and it has significantly revised it at least once since then. The policy is approved and marketed in 9 Western states. According to a report by ICF, Inc, only 7,000 individuals are insured under the policy. The company has just decided to make a nationwide marketing effort and it will be revising the policy to accomplich this.
Great Republic Life Ins. Co. Seattle, WA	Skilled nursing Care Policy UW-SNC-100	Limited to 6 Western states.

Table 1. Cont'd.

Company	Policy Name and Number	Comments
Health Insurance Corp., Milwaukee, WI		The company is listed in Meiners' study (The State of the Art in Long-Term Care Insurance) as selling a long-term care policy. Meiners summarizes the major features of the policy, but suggests that it is no longer available because of the Wisconsin rule governing nursing home insurance. The company could not be located.
Lumbermens Mutual Casualty Co. (Kemper Group) Long Grove, Ill.	Accident and Sickness Policy IA 5841	In late 1983, the company withdrew this policy in approximately one half of the states in which it had been originally approved due to unacceptable losses. The policy is currently available in 16 states. The report by ICF, Inc. estimates that 8,000 are insured under the policy.
Massachusetts Indemnity and Life Ins. Co. St. Louis, MO	Group Skilled and Intermediate Nursing Care Plan, GP8200	The company used to sell an individual long-term care policy, but stopped in 1981 because of unacceptable losses. The group policy is available in 30 states.
Merchants and Manufacturers Ins. Co., Cleveland, Ohio		The company is listed in Meiners' study as having a long-term care policy. Detailed information is provided in the study about policy features and premiums. A company representative, however, says the policy was never marketed.
Mutual of Omaha Ins. Co., Omaha, Neb.	NH-1	The company introduced this policy in mid-1984. It has been approved in 45 states but is not being marketed yet.

Table 1. Cont'd.

Company	Policy Name and Number	Comments
Mutual Protective Ins. Co/Medico Life Ins. Co. Omaha, Neb	Nursing Home Care Policy MP335J	The company has developed several policies; no information could be obtained about the extent of its marketing efforts.
National Foundation Life Ins. Co., Fort Worth Texas	Health Care Policy HC-Shell	The company reports that its policy is marketed in the 26 states where the company is licensed, realizing several million dollars in premiums in the three years the policy has been available.
Penn Treaty Life Ins. Co. Allentown, PA	Skilled Nursing Home and Custodial Care Policy NHP-800 GR	The policy is approved in two states and only marketed in Pennsylvania.
Prudential Ins. Co.		The company is developing a long-term care policy for AARP members. Test marketing is scheduled to begin in Spring, 1985.
Sterling Life Ins. Co. Springfield, OH	Skilled Nursing Home Benefit Policy S2212S	The company took over the nursing home business of Federated American. It has developed its own policy, which has been approved in three Northwestern states. The policy is only available in two states.
Transport Life Ins. Co., Fort Worth, Texas	Convalesent Care Policy 10576	The individual policy has been approved in 33 states, mostly in the South, Midwest.
	Group Convalescent Care Policy 10618	The group policy is for members of the North American Consumer Alliance and can be sold in 28 states. The company has been selling these policies for 4 years. It writes about 10,000 convalescent policies per year with premiums of $5 million in 1984.

Table 1, Cont'd.

Company	Policy Name and Number	Comments
United Equitable Ins. Co. Lincolnwood, Ill.	Nursing Home Policy 740	Marketing in more than 40 states, 40-50,000 policies are reportedly in force and earned premiums are running at $30 million.
World Life and Health Ins. Co. of Pennsylvania King of Prussia, PA	Senior Care II: Skilled Nursing Facility Indemnity Policy WLNH-4	This policy is marketed in 12 scattered states with most of the business in the East. The company has been selling its current policy for 2 years. The policy is a revision of an earlier version which it sold for approximately 1 year.

delivered services are thought to be refractory from the insurance point of view. The control of unnecessary utilization and the risk of adverse selection are twin demons which haunt this product line. In addition, the lack of reliable cost and experience data lead to serious problems in product design and pricing. A third barrier that is sometimes advanced is the presence of restrictive state regulation. Rules governing minimum loss ratios, reserve requirements and benefit design have been singled out for special notice. Finally, the availability of public benefits for long-term care, particularly Medicaid, are generally thought to have deterred full development of the private market. Although further deterioration in Medicaid eligibility and long-term care benefit levels looms rather plainly on the horizon, there continues to be widespread confusion among young and old alike regarding Medicare and Medicaid coverage of nursing home and health/home-care expenses.

Certain recent developments and activities suggest however, that the market may be ready to enter a new phase of growth. For example, the principal trade association of the for-profit nursing home providers, the American Health Care Association (AHCA), has undertaken an aggressive program to promote the development of private long-term care insurance. The AHCA has published a number of articles, reports and pamphlets, sponsored a set of seminars involving insurers, consumers, providers and government and has testified in support of man-

dated benefits legislation in at least two state legislatures.

Two insurance industry trade organizations, the Health Insurance Association of America (HIAA), and the Blue Cross-Blue Shield Association of America (BC-BS), have prepared reports on long-term care insurance and BC-BS has begun to develop a set of prototype benefits in conjunction with approximately twelve local Plans.

More significantly, several large insurers with national marketing capabilities have either introduced long-term care products or are on the verge of doing so. In June of 1984, Mutual of Omaha began seeking approval from state insurance departments for its skilled nursing policy. Prudential will reportedly begin test marketing a policy for members of the American Association of Retired Persons (AARP), sometime in the Spring of 1985. Because of the size of the AARP membership and the strength of the Association's commitment to a long-term care product, the Prudential venture is viewed by many as a bellweather for the field.

The pace of governmental activity has also picked up in 1984. The US Senate Special Committee on Aging held hearings on long-term care insurance as did two state legislative committees. Several of the state legislatures are expected to follow suit in 1985. In late 1984, two state insurance departments began a review of their policies toward long-term care products and the National Association of Insurance Commissioners (NAIC), organized a task force to examine the subject.

Taken together, these activities have begun to raise the level of public awareness regarding long-term care insurance. AHCA and others have undertaken the task of developing a broad constituency for private insurance including health care providers, insurers, governmental agencies and potential consumers. With the declining chances of major new governmental initiatives in long-term care financing, the private sector may well channel additional effort into this market.

Key features of long-term care insurance policies.

Table 2 outlines major features of sixteen insurance policies now offered by fifteen different companies. With two exceptions (Massachusetts Indemnity-GP8200 and Transport Life 10618) the policies listed are marketed to individuals. The remainder of the section supplements Table 2 with a discussion of (1) benefit levels, (2) definitions of covered benefits, (3) benefit periods, (4) pre-existing condition clauses, (5) the coverage of nervous and mental conditions and (6) premiums.

Benefit Levels

Twelve of the sixteen policies identified in Table 2 indemnify the subscriber up to a specified daily or monthly dollar allowance. The remaining policies pay actual charges, usual and customary charges or incurred expenses for covered benefits up to daily or monthly limits.

Ten of the sixteen policies either require an elimination period (i.e. deductible) or offer one or more low option plans

Table 2. Policy Characteristics (Highest and Lowest Option Plans Offered, If Applicable)

	Benefits (Covered Level of Care)				Deductible	Benefit Limits		Pre-Existing Condition	Mental/Nervous	Limit on Issue Age	Renewability	Annual Premium If Issued at Ages 65 & 75	
	SNF (1)	ICF (2)	Custodial (3)	Home (4)	(5)	Per Benefit Period (6)	Lifetime (7)	(8)	(9)	(10)	(11)	(12)	
												Low Option	High Option
A. Columbia HMOS-01	$10/day -50	$10/day -50	$10/day -50	None	0 days -100	SNF.....5 yrs ICF.....6-12 mos Custodial	$30,075-109,500	6 mos for conditions within pre-ceeding 5 yrs	Excluded	60-74	Non-renewable by State	Age 65.....$58 75.....85	$438 675
B. Continental Casualty P1-5221-2-697	$10-55	$10-55	None	None	0 days	SNF.....2 yrs ICF.....2 yrs	None	90 days for conditions within pre-ceeding 2 yrs	Excluded	60 plus	Non-renewable by State	65.....$69 75.....78	$381 430
C. Equitable Life and Casualty #439	$10-40	$50-30	$2.50-15.00	$1.25-7.50	0-100	SNF.....2 yrs ICF.....2 yr Custodial..6 mos Home.....30 days	$15,000-90,000	6 mos for conditions within pre-ceeding 5 yrs	Excluded if no demonstrable organic disease	50-85	Guaranteed renewable	65.....$60 75.....72	$276 433
D. Firemen's Fund 6316-4-81	$10-70	$10-70	$10-70	$5-35	20-100	SNF.....1440 days ICF..... " " Custodial.. " " Home.....180 days after-SNF..180 consec-utive days	None " " " "	90 days for conditions preceeding effective date	Excluded if no demonstrable organic disease	-83	Non-renewable by State	65.....$90 75.....102	$130 132
E. Crown Republic UW-EHC-100	$20-30 up to 100th day, $40-60 thereafter	None	$40 rider	$30 for Private duty nurse	0	SNF.....3 yrs Custodial...$21 days Pvt. nurse..3 yrs	None "	1 yr for conditions within pre-ceeding 1 yr	Not Excluded	55 plus Custodial rider up to age 84	Guaranteed renewable	65.....$125* 75.....407*	$375* 495* *Includes Custodial Rider
F. Lumberman's Mutual #65841	$10-30 up to 100th day, $20-40 thereafter	$10	$10	$25 for Private duty nurse	0	SNF.....3 yrs ICF.....60 days Custodial. 60 days Pvt. nurse..) yrs	None " " "	1 yr for conditions within pre-ceeding year	Excluded	50-74	Non-renewable by State	65.....$312 75.....374	$351 444
G. Massachusetts Indemnity GP8360	$25 up to 61st day; $50 there-after	$25 up to 61st day; $50 there-after	None	None	60 days for per-sons aged 65+	None	$75,000	1 year for conditions within 1 preceeding yr	Excluded if no demonstrable organic disease	18-	Voluntable with 31 days notice	65.....$310 75.....	$300
H. Mutual of Omaha MB3	$20-40 up to 91st day; $10-20 there-after	$30-40 up to 91st day; $10-20 there-after	None	None	0	SNF .....1 yr ICF..... " "	None "	6 mos for con. itions within pre-ceeding 6 months	Not Excluded	65-	Non-renewable by State	65.....$31 75.....44	$180 227
								6 mos for conditions within pre-ceedin. 5 yrs	Excluded if no demonstrable organic disease	18-84	Non-renewable by State	65.....$164 75.....202	$769 $14

J.	National Foundation BC-Shell	$20-90	$20-90	$10	$14; $80 for Private nurse	30 days for Custodial care	SNF.....3 yrs ICF.....3 yrs Custodial..120 days Hosp.....equal to no. of hosp. days Pvt. nurse..30 days	None " " "	2 yrs for 6 mos if 65 or issue) for conditions within preceding 5 yrs	Excluded	---	Guaranteed Renewable	Unavailable		
K.	Penn Treaty HHP-800CR	$7-60	$7-60	$7-60	None	30 days	SNF.....5 yrs ICF....." " Custodial..5 yrs	None	6 mos for conditions within 30 days after effective date or 5 yrs preceding	Excluded	60-	Guaranteed Renewable	65....$135.....$1,215 71....178.....1,602		
L.	Sterling Life S 22125	$30-90	$30-90	$30-90	None	20 days	SNF.....6 yrs ICF..... Custodial..6 yrs	$61,800- 73,000	30 days for conditions after effective date	Alzheimer's disease	50-84	Non renewable [illegible] rate	65....$290.....$505 71....290.....505		
M.	Transport Life (Group) 10618	$10-30 up to 100 days; $20-60 day 101 to 2 yrs; or $20-60 from day 1	$10-30 up to 100 days; $20-60 day 101 to 2 yrs; or $20-60 from day 1	$5-15	None	0-100 days	SNF.....2 yrs ICF..... Custodial..120 days	None	6 mos for conditions within preceding 12 mos	Excluded	60-84		65....$77.....$365 71....121.....572		
N.	Transport Life (Individual) 10576	$20-60	$20-60	$5-15	None	30	SNF.....2 yrs ICF..... Custodial..120 days	None	6 mos for conditions within preceding 12 mos	Excluded	60-84	Guaranteed Renewable	65....$156.....$266 71....468.....733		
O.	United Equitable 760	$20-60	$10-30	$10-30	None	0-100	SNF.....6 yrs ICF.....6-12 mos Custodial..6-12 mos	$30-90,000	6 mos for conditions within preceding 6 months	Excluded without demonstrable organic illness	62-79	Guaranteed Renewable	65....$90.....$78 71....310.....822		
P.	World Life	$10-53	$10-53	$10-53	None	0-20	SNF.....6-24 mos ICF..... Custodial..6-24 mos	None	3 mos for conditions within preceding 5 yrs	Excluded	60-84	Guaranteed Renewable	65....$89.....$180 71....117.....210		

Legend

Low Option: minimum daily benefit, highest available deductible, highest limit per benefit period and lifetime, best risk category.

High Option: maximum daily benefit, lowest available deductible, highest limit per benefit period and lifetime, best risk group.

which contain a deductible feature. Half of these policies contain a one hundred day elimination period option; the balance offer more immediate coverage.

Maximum daily (monthly) benefits for skilled, intermediate, custodial and home care vary sharply from policy to policy. Table 3, below, summarizes the range of benefits offered for different types of coverage.

Table 3. Ranges of Daily Benefits by Type of Coverage

	Lowest Benefit	Highest Benefit
SNF	$7* (Penn Treaty-Lowest Option)	$70 (Fireman's Fund-Highest Option)
ICF	5 (Equitable Life-Lowest Option)	70 (Fireman's Fund-Highest Option)
Custodial	2.50 (Equitable Life-Lowest Option)	70 (Fireman's Fund-Highest Option)
Home (unrestricted)	1.25 (Equitable Life-Lowest Option)	35 (Fireman's Fund-Highest Option)
Home (Pvt. duty nursing)	25 (Lumbermen's Mutual)	80 (National Foundation)

*Excludes $6 Mutual Protective benefit for days 1-20 only.

Seven policies provide low option SNF coverage at the $10 per day level while fourteen policies offer high option coverage for some or all covered days at the $50 level or above.

While a total of thirteen policies made provision for custodial care (either directly or through riders), only seven provided maximum per diem benefits of $30 or more. Among the rest, the average high option benefit was $12.50. Most low option benefits fell in the range of $5 - $10.

Only four companies provided unrestricted indemnity coverage during home confinement almost all cases maximum daily benefits were less than $

Definitions of covered benefits

Close examination of sixteen policies listed in Table 2 shows there is virtually no consistency in the way covered benefits are defined. The policies considered in this report differ widely across three major axes: (1) covered services, (2) eligible facilities and (3) acceptable levels of care. The policies also diverge with respect to conditions such as prior hospitalization and the maximum interval between hospitalization and long-term care confinement. These additional variations will not be discussed in this report.

While all sixteen policies provide a skilled nursing benefit

- 5 define skilled care and will cover it only in defined skilled nursing facilities
- 4 define skilled care but will provide benefits in a range of facilities

• 3 define skilled care and cover confinements in skilled nursing facilities but also undertake to continue benefits if care is reduced to a lower level including custodial care

• 4 do not clearly define skilled care but will pay for medically necessary confinement in skilled nursing facilities

Looking further, it is clear that even within these categories, material but often subtle distinctions prevail. Three policies --- Sterling, World and Fireman's --- for example, provide for the continuation of skilled benefits even when the level of care is reduced. A comparison of relevant provisions further illustrates the issue of noncomparability.

Eligible facility	Sterling- SNF is defined as an institution which is regularly engaged in providing continuous skilled nursing services.
	World- SNF is defined as an institution which is approved for payment of Medicare benefits or is qualified to receive approval if requested and which is primarily engaged in providing skilled nursing care.
	Fireman's- SNF is defined as a facility which is regularly

	engaged in providing continuous skilled nursing care.
Covered services	Sterling - If care is reduced, after admission to a SNF, to a level that is primarily custodial, confinement will be considered necessary if it is medically determined to be essential to the health and wellbeing of the patient. World - Benefits will continue even though the level of care changes to custodial once a planned program of observation and treatment has begun. Fireman's - Benefits will continue if care after admission is reduced to a level that is primarily custodial.

A similar point could be made about the imprecision and variation of definitions of intermediate, custodial and home care.

Benefit Periods

The policies also differ markedly with respect to their treatment of benefit (or confinement). Inasmuch as many service users will have an interruption during the course of their stay (through discharge, transfer or change in level of care) it is important to know how such breaks affect benefits.

In some cases, a break in confinement creates an entirely new benefit period. This , in turn, forces the subscriber to meet a fresh round of deductibles or to absorb a reduction in the daily benefit level. In other cases, separate episodes during a broken confinement are added together to count against the limitation on covered days during a single benefit period.

Many of the policies and accompanying literature we examined were vague or silent about their treatment of benefit periods. In view of the frequency with which confinement periods are broken among the long-term care population, greater precision on this point would seem important.

An example of some of these differences is illustrated below.

Mutual Protective — "Confinement period starts with the first full day you are confined in a covered facility and receive benefits under the policy. It ends when you are no longer con-

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-fined in a covered facility. If you are in a confinement period, a return to the hosp-ital for less than three days in a row will not start a new confinement period. A return to the hospital for three days in a row or more, however, will start a new confinement period".

Comment: If a SNF patient is transferred on day thirty of his confinement to a hospital where he stays for a week and then is readmitted to the SNF for continuing care of the same diagnosis he would receive a reduced indemnity benefit (ie. the indemnity allowed for days 1-20 of a SNF confinement).

Lumbermen's Mutual — "For the purpose of determining the maximum benefit payable for any one accident or sick-ness, successive periods of confinement while this policy is in force due to the same or related cause or causes, shall be considered as one continuous period of confine-

-ment unless such periods are separated by six consecutive months or longer during which you resume your normal activities, in which case this subsequent confinement will be considered as a new confinement for benefits purposes". (Emphasis added)

Comment: This policy seems to impose the condition that someone discharged from a skilled facility and then readmitted more than six months later must have resumed her normal acitivities in order to begin a new benefit period.

Pre-existing Conditions

All policies contain provisions excluding coverage for pre-existing conditions for periods ranging from thirty days to two years following date of issue. Definitions of pre-existing conditions vary as do the pre-issue treatment periods. The latter range from one month to five years.

Nervous and Mental Conditions

Only two policies contain no provision excluding coverage for mental or nervous diseases or disorders. Eight policies exclude coverage for such conditions in their entirety. The remaining six policies exclude benefits unless there is a demonstrable

organic disease present. This has obvious implications for victims of Alzheimer's Disease.

Premiums

It should be clear from the information arrayed in Table 2 and summarized in this section that a direct comparison of premiums across all policies would lack meaning and would tend to create confusion. Inconsistent definitions, divergent benefits, individual limitations and conditions make it virtually impossible to develop a valid price comparison.

At age 65, very limited benefits can be had for less than $5/month (Columbia, Equitable Life, Mutual of Omaha and United Equitable) while more extensive coverage can cost as much as twenty times that sum (Penn Treaty). At age 71, three low option policies are available for less than $7/month (Continental Casualty, Equitable Life and Mutual of Omaha). At the other end of the spectrum seven policies are offered for more than $40/month (Columbia, Great Republic, Penn Treaty, Transport Life Group and Individual and United Equitable).

The affect of increasing age on monthly premiums varyies significantly from policy to policy. Table 4, below, shows the range of differentials, looking at the cost of policies issued at ages 65 and then at 71.

Table 4. Premium Differentials at Two Issue Ages*

Premiums at Age 71 Are Higher Than at Age 65 by:	Number of Low Option Plans	Number of High Option Plans
0-10%	2	2
11-20%	3	3
21-30%	4	3
31-40%	1	2
41% +	5	5
	15	15

*Quotations are not available for one company

It is interesting to note that most companies apply the same differential to their highest option plans as they do to their lowest option products (As more experience is collected, it is likely that less arbitrary pricing rules will be applied).

II. State Regulation

Regulation by state insurance departments has been identified in many studies and policy papers on long-term care insurance as one of the important barriers to development and expansion of the market. Mark Meiners of the National Center for Health Services Research (U.S. Department of Health and Human Services) states that it is common to find long-term care insurance products subject to state Medicare supplement regulations. ICF, Inc. also points out that long-term care policies

are often subject to MEDIGAP rules. Those viewed negatively include mandated benefit requirements, broad definitions of covered care, minimum loss ratios, restrictions on underwriting for health conditions, limitations on pre-existing condition waiting periods and the use of age-rated premiums. The American Health Care Association singled out restrictions on indemnity policies and reserve limitations as "major disincentives" to long-term care insurance. The AHCA called insurance regulation reform a principal component of its promotional strategy.

Although numerous alarms have been sounded about adverse regulatory practice, the basis for these concerns has not been well documented. In practice, most long-term care policies appear to be routinely approved in the states in which they have been filed. The two companies that have filed their policies in the largest number of states---Mutual of Omaha and United Equitable---have successfully obtained approval in all but five or six. The United Equitable policy, with minor variations, has been approved in forty-two states and the District of Columbia. Twenty-six of these states have approved the basic policy without requiring any change. United Equitable indicates that the modifications required in the other states have been mainly insignificant.

The Mutual of Omaha policy has been approved in forty-five states since its introduction in 1984. Three other companies, CNA, Lumbermen's Mutual and Transport Life, have had their policies approved in more than 30 states.

To obtain more precise information about the regulatory environment we surveyed six states---Florida, Massachusetts, New York, Pennsylvania, Washington and Wisconsin---to determine what specific actions have been taken on long-term care products. Table 5 provides the results of this survey.

In brief, Table 5 shows that of the forty-six policy forms that were filed in the six states, thirty-five or seventy-six percent were approved.

Of the states surveyed, Florida, Washington and Pennsylvania have been most active. The Florida Department has approved all eleven policies filed to date; the Washington Department disapproved two of the thirteen filed with it. It appears, however, that disapprovals were the result of a failure of the companies to respond to certain of the Department's comments. Similar policies, filed by the same companies at an earlier date, had been approved by the Department.

Actions by the Wisconsin Department merit special attention. In 1981, Wisconsin adopted a specific regulation governing individual nursing home policies. Since then, only one policy subject to the rules, United Equitable, has been approved. United Equitable reports that the policy is not being marketed in Wisconsin because the indicated premium (attributable to regulation) is too high. Most companies have not bothered to file in Wisconsin, allegedly because of limitations imposed by the 1981 regulation.

In Massachusetts, the sole policy that is reported to have been disapproved is a Continental Casualty product filed ten years

ago. CNA reports that the policy failed to meet Massachusetts readability requirements and that it has been revised and will probably be resubmitted in the not too distant future. More recently filings by other companies have been routinely approved by the Massachusetts Department.

Table 5. Policy Approval Status in Six States

Company	Policy	Fla.	Mass.	N.Y.	Penn.	Wash.	Wisc.
Columbia	NHC683				Y		
CNA	52212	Y	W	W	W	Y	W
Equitable	435					Y	
Fireman's	6318	(5)				Y	
Great Republic	UW-SNC-100					Y	
Lumbermen's	IA5841	Y	Y	D	Y	Y	Y(15)
Mass. Indemnity	GP8200(1)	Y	Y				Y(16)
Mutual of Omaha	NH1	Y	Y(9)	Y(11)	Y	Y	W
Mutual Protective	335J	Y(6)			?(12)	(13)	
	436(2)	Y			Y	D	
National Foundation	HC-Shell	Y(7)				Y	

Table 5., Cont'd.

Company	Policy	Fla.	Mass.	N.Y.	Penn.	Wash.	Wisc.
Penn Treaty	NHP800GR				Y		
Sterling	S2212S					Y	
Transport Life	10576	Y			Y	Y	
	10618(3)	Y				D	
United Equitable	740(4)	Y(8)	Y(10)	?	?	Y(14)	Y(17)
World	WLNH-4				?		

Legend--1. Footnotes are indicated by a parenthesis. Notes to this Table will be found at the end of the report.
2. Y indicates that the policy has been approved.
3. D indicates that the policy has been disapproved.
4. W indicates that the policy has been withdrawn.
5. ? is used when it is unclear from the department and the company whether the policy was formally disapproved after filing.
6. Blanks indicate that the company is not licensed or the policy was not filed.

Regulatory Standards

In addition to surveying the actions taken by the six state departments with respect to specific policies, we reviewed their regulations and interviewed representatives of each of the six departments to determine the standards applied to long-term care products.

Only one state, Wisconsin, has a specific rule setting forth mandatory benefits for long-term care policies. The other states apply the rules governing individual or group health policies; with very limited exception, the states do not apply MEDIGAP rules or other regulations mandating benefit levels.

• All of the states do require some form of special disclosure regarding the benefits provided.

• In four of the states, minimum loss ratio requirements ranging from 50% to 65% apply to long-term care insurance.

• Four states also require conformity with prescribed definitions of skilled nursing facilities.

Table 6, below, summarizes the rules and practices adopted by the six states surveyed.

Table 6. Application of Regulatory Standards to Long-term Care Insurance*

		Fla.	Mass.	N.Y.	Penn.	Wash.	Wisc.
1.	Individual Accident & Health Regulations	Y	Y	Y	Y	Y	Y
2.	MEDIGAP Regulations	N	N	N	Depends	N	Depends
3.	Minimum Benefit Standards	N	N	N	N	N	Y
4.	Minimum Loss Ratio	N	Depends	65%	50%	60%	N
5.	Special Disclosures	Y	Y	Y	Y	Y	Y
6.	Definition of Facilities	Y	Y	N	Y	Y	N

* See Notes to this Table at end of the Report.

Recent Regulatory Developments

Interviews with insurance department officials provided helpful information about current thinking and about activities underway or planned.

Florida recently began an internal review of Department policy toward long-term care insurance. Among other things the department expects to develop a consumer guide.

New York convened a task force of industry representatives in November, 1984, to discuss long-term care business. The task force is expected to meet again in several months. The Department has expressed open concern about the unavailability of long-term care coverage (only Mutual of Omaha has been approved) and state insurance officials are interested in stimulating development. At present, policies must be labeled as minumum benefit health insurance. Because this label may discourage insurers, consideration may be given to a new classification for long-term care coverage. Some consideration is reportedly being given by other state agencies to a mandated long-term care insurance approach but the near term outlook for it is deemed to be unfavorable.

Washington The insurance superintendent has been named Vice-Chairman of the NAIC task force on long-term care insurance.

Wisconsin In 1981, the department promulgated a rule (WAC Ins. 3.46) setting standards for nursing home insurance. The rule was developed in response to problems with a company

which was put into receivership. Many policy holders were misled about the extent of the coverage. The findings incorporated in the rule state:

> "...[S]ignificant misunderstanding exists with respect to nursing home insurance. In many cases, coverage under these policies is much less than the use of the label would warrant and includes few meaningful benefits beyond those already available to consumers as a result of [Wisconsin law and regulations] and the Commission finds that such policies are inequitable, misleading, deceptive, obscure and encouraging of misrepresentation....Some of the sales presentations used to sell nursing home insurance are misleading, confusing and incomplete..."

The rule establishes a minumum daily benefit of $10, a maximum deductible of sixty days per lifetime and a minimum of one year of coverage. Most significantly, it prohibits provisions which limit coverage to specified levels of care, to care received as a result of sickness or injury and to care received after hospital confinement. Inasmuch as the products surveyed in this report contain all three restrictions, the regulation has effectively barred long-term care insurance sales in Wisconsin. Only one company, United Equitable, has had an individual policy approved since the adoption of the 1981 rule. To obtain approval, the company had to develop an entirely different product which it does not sell because it is viewed as being prohibitively expensive. It should be noted parenthetically that the Wisconsin regulation applies only to individual policies.

Other States During 19 legislation was filed in at least four states, Kentucky, Michigan, New Jersey and South Dakota, to mandate nursing home coverage as part of other health insurance or to require that certain types of care be covered in nursing home policies. Several other state legislatures are reportedly expected to consider similar proposals in 1985. The American Health Care Association has generally supported and encouraged legislation of this type.

III. Interviews with Selected Organizations

To get a cross section of views on private, long-term care insurance, particularly on the role of state regulation, we interviewed representatives of trade, consumer and government organizations that have had an active interest in the field. (A listing of the organizations and contact people will be found at the end of this report). A summary of the activities and views of each of these organizations is provided below.

American Association of Retired Persons (AARP)

In late 1983, AARP commissioned a Gallup survey of its members to determine their preferences and needs relative to long-term care insurance. The survey concluded:

- that an overwhelming majority (80%) of AARP members would prefer long-term home health care to long-term nursing home coverage. Approximately the same percentage believed that AARP should develop insurance that covered both home and nursing home benefits.

- there is a great deal of confusion about the protection offered by Medicare for extended care. 79% of the respondents believed Medicare would pay for all or part of an extended confinement at home or in a nursing facility.

Based in part upon the survey results, AARP has asked Prudential Insurance Co. to develop a long-term care product for its members. The policy will feature:

- daily indemnity benefits for skilled, intermediate/custodial and home care.
- a prior confinement (hospital or nursing home) requirement before the home-care benefits kick-in.
- a health statement (the first time for an AARP-sponsored insurance product).
- a maximum issue age of 80.
- a pre-existing condition provision.

AARP expects Prudential to begin test marketing the policy in April, 1985, in those states with a high concentration of members and more permissive insurance regulations. The policy will be marketed by direct mail.

In testimony before the US Senate Special Committee on Aging, AARP made the following points:

1. The absence of adequate cost, price, utilization and other predictive data has made the introduction of private long-term care insurance extremely risky, at best. (At the seminar in December, Prudential's actuary said that the lack of data constitutes the most serious problem in developing long-term care insurance).

2. Coverages are widely misunderstood and purchasing decisions are frequently made with wholly inadequate information. State and Federal regulations should require adequate disclosure through coverage outlines and buyers' guides.

3. While the elderly have clearly indicated a need and desire for some form of long-term care insurance, private insur-

ance is only one part of the answer to financing long-term care.

AARP has also expressed concern about the ability to introduce its insurance product in states that have rigorously regulated its Medicare-supplement policies. States singled out for special notice were Florida, Michigan, Minnesota and Wisconsin. States which established minimum loss ratios were considered particularly troublesome.

American Health Care Association (AHCA)

The AHCA is the principal trade association of the for-profit nursing home industry. AHCA has been one of the most active organizations in the country in the area of long-term care insurance development. In January, 1984, the AHCA issued a report titled "Private Insurance for Long-term Care: Availabity, Problems and Action". The organization has sponsored several seminars, testified before the US Senate Special Committee on Aging and before State legislative committees considering mandated long-term care benefits.

The AHCA materials make the following points:

- There is widespread misunderstanding among the elderly about the protection provided by private insurance coverage. MEDIGAP policies have sometimes been marketed without clearly stating the protection afforded for long-term care.

- State legislative committees should be encouraged to look at regulations which serve as disincentive to private long-term care insurance. Regulations which impose restrictions

on indemnity policies and which set reserve limitations merit special attention. Other problems include pre-existing illness limitations, and required coverage for those unable to meet health screenings.

- Application of MEDIGAP regulations to long-term care policies would seriously restrict coverage and impede the development of the market.

- State insurance officials should not have broad authority to set loss ratios for long-term care policies. Insurance companies have a valid concern that limited risk experience and applicable actuarial data are significant obstacles to entry into this market. Insurers should therefore have greater flexibility than elsewhere in view of the level of risk and uncertainty.

Blue Cross-Blue Shield Association (BC-BS)

Blue Cross-Blue Shield is working with approximately 12 member organizations (including Massachusetts) to develop one or more prototype policies (possibly going beyond indemnity benefits). The current time schedule calls for prototype development to be completed by the Spring of 1985. The present schedule also contemplates the availability of product(s)by the middle of 1986. Blue Cross-Blue Shield believe that the market is extremely risky and that there is significant potential for adverse selection and excessive utilization. The Association has expressed concern about the potential impact of state regulation on

long-term care policies, especially in the area of minimum loss ratios.

Health Insurance Association of America (HIAA)

HIAA established a task force to study long-term care in 1981. The Association published a report in 1984 entitled "Long-term Care: A Challenge to Society". The report makes the following points:

- Medicaid discourages the development of viable private financing options because it is viewed by many as providing broad, nearly universal coverage.
- Benefits should be limited to "medical care"; custodial care coverage should be limited to situations in which it can optimize a person's functional status.
- More precise definitions of level of care (skilled, intermediate, convalescent, day-care, home-health and hospice) are needed.
- Adverse selection is potentially a very serious problem. The insurers will need to use individual underwriting, pre-existing condition clauses, upper age limits on eligibility etc..., and will also have to devise plans to attract younger persons.
- The expansion of long-term coverage will create even greater demands for service. Induced demand is likely to become a serious problem, particularly for home-care coverage.
- The current regulatory climate is not responsive to

long-term care. For example, California considers home-care benefits more similar to disability coverage than to traditional hospital, medical and surgical benefits. A practical regulatory framework is needed to accomodate successful underwriting and marketing of long-term care insurance.

- The application of minimum loss ratios and mandated coverages serve as impediments to experimentation. Regulators must recognize that long-term care insurance is a hybrid product that requires new standards and approaches.

National Association of Insurance Commissioners (NAIC)

At its meeting in December, 1984, the NAIC expanded the charge of its Medicare Supplement Task Force to include long-term care issues. The Task Force is currently selecting members of an advisory committee.

National Association for Home Care (NAHC)

The NAHC began to focus attention on long-term care insurance in the Fall of 1984. Since that time, the Association has formed a Long-term Care Insurance Task Force, delivered testimony at the US Senate Special Committee hearing and sponsored a seminar in conjunction with the American Health Care Association, the AARP and the National Governors Association.

The NAHC has argued that long-term care insurance is needed because of the gaps in coverage afforded by Medicare and most supplemental insurance policies. It has also urged insurers to incorporate a significant home-care component among the benefits

provided.

Senate Special Committee on Aging

The Senate Committee, chaired by John Heinz of Pennsylvania, held hearings on long-term care insurance in September of 1984. Staff of the Special Committee prepared a briefing paper which indicated that:

- In 1984, the average annual cost of nursing home care ranged from $20-50,000.
- Private insurance pays for a very small fraction of nursing home care.
- Current long-term care insurance policies are oriented to skilled nursing. By not providing home-care benefits, the insurer can more easily define the insurable event and establish a clear need for the utilization of services.
- While failure to incorporate extensive home benefits in many insurance policies tends to stabilize premium costs, it also limits the attractiveness of the products. It may also deter efforts to shift the locus of care from institutions to home.
- The Committee does not plan to issue a report. Senator Heinz has expressed interest in establishing a Federal Commission on long-term care but postponed any action pending completion of a study by the Brookings Institution.

U.S. Department of Health and Human Services

The Department, through intramural and contract research, has been studying long-term care financing for several years.

Mark Meiners, of the National Center for Health Services Research, has worked extensively on issues related to the design, availability, cost, and demand for private long-term care insurance. Among other things, Meiners has observed that:

- Wisconsin's stringent regulations were implemented because the elderly could not easily understand the coverages provided and because of the potential for abuse. These rules, however, may stifle innovation.
- State rules limiting pre-existing condition clauses may not be appropriate to long-term care insurance because of adverse risk selection.
- Minimum loss ratios should not be the same for long-term care policies as for Medicare Supplement policies. Low loss ratios can be expected for long-term care policies in their initial years. Standards for minimum losses should be flexible and there should be no fixed loss ratio until the policy has been sold for some time.
- The tax treatment of reserves should be studied as a possible way to encourage insurers to develop this market.

ICF Inc. to D/HHS ("Private Financing of Long-term Care: Current Methods and Resources")

- Long-term care insurance may be subject to regulations governing Medicare Supplement policies.
- The most troublesome features of these regulations are comprehensive benefit requirements, minimum loss ratios, broad

definitions of covered services and restrictions on underwriting (eg. pre-existing condition periods and age-rated premiums).

IV. Some Major Regulatory Issues Identified in This Preliminary Survey.

This concluding section is an attempt to organize, in shorthand form, certain of the key regulatory issues identified in the text of the report. It is not meant as a summary of the preceeding chapters or as a recommendation for specific actions by the Division of Insurance.

Three principal themes have emerged quite clearly from our interviews, examination of policies and marketing materials, assessment of rules and regulations and review of the literature. They are (1) questions about the political-legal support systems necessary to promote product innovation in a traditional industry; (2) concerns about the nature and extent of the market, from both a sales, as well as a consumer protection point of view, and (3) uncertainty about the relationship between public and private long-term care financing.

The proper environment for product innovation.

In view of the relatively uncharted market (particularly from an actuarial perspective), plus the inherent risks involved with new long-term care products, industry experts and other informed observers have made out a *prima facie* case for regulatory flexibility and a learn-as-you-go posture.

It is not very clear, however, just what specific regulatory actions insurers would find supportive, hostile, or neutral

with respect to long-term care insurance. Nor is it immediately apparent that the type of indemnity options available right now (which are weighted heavily in favor of institutional care) will have the amount of appeal necessary to win mass support from consumers, health care providers and regulators. As state level task forces like those now operating in Florida and New York, proceed a bit further, perhaps the issues of regulatory policy and long-term care product design will be joined.

Special features of the market for long-term care insurance.

Many people believe that in order to become viable, long-term care insurance will have to become a group product-- sold to middle aged people well in advance of heavy benefit use-- as well as to senior citizens on an individual basis. While the present outlook for group sales to an employed population is speculative, the regulatory issues associated with developing such a market are substantial. Issues of solvency, reserve accumulation, financing, cancellation and renewal and long-term economic value are apt to be reasonably complex if and when long-term care insurance is sold to a mass market.

From a consumer protection perspective, this survey illuminates a great number of problem areas that may become more serious over time. They include unclear and imprecise benefit definitions, the lack of comparability between policies, confusing and potentially misleading limitations which have a tendency to

erode the economic value of policies, serious questions about age rating and underwriting standards.

Integration of public and private financing.

Many states, squeezed by rising Medicaid expenditures, may begin to equate private long-term care insurance with budgetary relief. However, just as commercial insurers are right to be concerned about the threat of adverse risk selection in this market, so too should state governments. If private insurers are at liberty to select only the best risks through discretionary underwriting, the residual left to Medicaid, may be very costly. This problem is compounded by the many benefit limitations currently written into long-term care products. As people use up their lifetime benefits, after, say, three or four years in a long-term care institution, they may then become Medicaid eligible. Predictably, the costs to Medicaid at that point, will be extremely high.

In conclusion, it is likely that in the near future, state insurance departments will be faced with major decisions both about specific insurance policies and protections and in the larger scheme of things, about the extent to which they wish to stimulate private development of this market. Hopefully, this background report will be of help to the Massachusetts Division of Insurance in working through these complicated questions.

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Notes to Table 2

A. Columbia-NHC 683 - We were unable to obtain a copy of this policy from the company. The information, therefore, is derived from an outline of coverage and an application form. Premiums are fixed at age of enrollment.

B. Continental Casualty - P1-52212-A97-CNA has devised four health rating groups based upon 146 "substandard" conditions. Ten conditions are specified as "uninsurable". Company guidelines also indicate that certain multiple or severe conditions may disqualify insurance applicants.

Premiums appear to vary in five year blocks by attained age through age 85.

C. Equitable-435-This policy is different from the others considered in Table 2 in that it employs specific "level of care" definitions in the description of benefits. Thus, for example, a subscriber must be receiving one of nine qualifying "skilled" services to receive SNF-level benefits; similar definitions are used for rehabilitation, personal care, intermediate nursing care and custodial care.

Premiums appear to be based upon the subscriber's age at enrollment although the policy is not entirely clear on this point.

D. Firemen's Fund-6318-6-81-This policy does not contain a clearly identifiable pre-existing condition clause. The information in Table 2 is derived, therefore, from an outline of coverage, the policy summary and the definition of "sickness" contained in the policy. Premiums are based upon the subscriber's age at enrollment.

E. Great Republic-EW-SNC-100-This policy has a rider which pays benefits for persons confined in a custodial care facility. Reimbursement is made on an actual charge basis up to $40 a day. Unlike many other policies summarized in Table 2, Great Republic provides benefits for private duty nursing during home confinement. (Other policies tend not to require the provision of particular medical services).

Premiums are based upon age at enrollment.

F. Lumbermen's Mutual-IA5841-A rider to this policy provides the coverage for intermediate and custodial care services after twenty days of skilled-level care. The home benefit is restricted to private duty nursing.

Premiums are set at the age at enrollment.

G. Massachusetts Indemnity-GP8200-This group policy does not contain a separately identified pre-existing condition clause. The restrictions are included in the exceptions and limitations provision.

Premiums vary by attained age in five year blocks through age 85.

H. Mutual of Omaha-NH2- NH2 is the form approved in Massachusetts. The basic form - NH1 - could not be obtained. This policy does not contain a separately identified pre-existing condition clause. The restrictions are spelled out only in the outline of coverage.

Premiums vary by attained age in multi-year blocks.

I. Mutual Protective-335J - This policy uses health condition in the rating process. In addition to a basic rate, separate premiums are calculated for persons with one and two defined medical conditions. The policy application requires a health statement for approximately thirty different conditions.

Premiums vary by attained age in multi-year blocks.

J. National Foundation-HC-Shell - This policy pays usual and customary charges up to the daily limit. Specific premiums were not made available to us. The policy specifies, however, that rates vary by original issue age and that premiums may change by rating class. The class is contingent upon issue age, issue year, sex and state of residence.

K. Penn Treaty-NHP-800-GR - This policy contains no specifically labelled pre-existing condition clause. The confusing limitations are contained in the definition of "sickness" and in the provision establishing the time limit on certain defenses.

Premiums vary by age at enrollment.

L. Sterling Life- S22125 - This policy does not contain a clearly labelled pre-existing condition clause. Limitations however, are contained in the definition of "sickness" and are described in the outline of coverage and in marketing pamphlets. There does not seem to be any time limit preceeding issuance of the policy during which conditions were treated.

Premiums are established on an issue age basis.

M. Transport Life (Group)-10618 - Although under the high option plan, benefits become available on the first day of confinement, the policy excludes coverage until the policy has been in force for thirty days. Premiums vary according to issue age.

N. Transport Life (Individual)-10576 - The individual policy has the same limitations as the group benefit.

O. United Equitable-740 - Premiums vary by issue age.

P. World Life-WLNH-4 - Benefits do not become available until thirty days after the date of issue. Premiums vary by issue age.

Notes to Table 5.

1. This is a group policy that is not subject to filing and/or approval in many states. Where it has been affirmatively approved, the standards applied will generally have been as rigorous as for individual policies. Massachusetts Indemnity is not licensed in New York and the policy has not been submitted for approval in Pennsylvania or Washington.

2. Mutual Protective has an identical product offered through its affiliate Medico Life (ML436). The Table only includes the Mutual Protective policy because it is the more widely offered product.

3. This is a group policy. See note #1.

4. United Equitable offers an identical product (640) through its life insurance affiliate. The Table only includes the policy 740 because the existence of the 640 series was only recently discovered.

5. A Florida insurance department report indicates that another Fireman's Fund long-term care policy (6322-A-2-83) has been approved. The Table does not reflect this policy because its existence was only recently discovered.

6. A revised form, 335JF, was approved.

7. A revised form, 83-FL, was approved.

8. A revised form, 740-2, was approved.

9. A modified form, NH2, was approved.

10. Form 640 was approved.

11. A modified form, NH3, was approved.

12. The Pennsylvania Department reports that this policy has not been approved. Mutual Protective indicates that it has been approved but that policy summaries were never printed for Pennsylvania because of a lack of agency activity.

13. Washington Department indicates that an older version of this policy (335), which is no longer being marketed, was approved. The Department's records, however, did not reflect approval of 335J.

14. A revised form, 740-10, was approved.

15. This policy was approved before Wisconsin adopted its nursing home insurance regulation in 1981.

16. This is a group policy and is not subject to the Wisconsin rule.

Notes to Table 6 .

Florida

Individual Accident and Health Regulations - Florida Administrative Code (FAC) c.4-37, governs all individual accident and health insurance policies.

Minimum Benefits - Long-term care insurance is considered non-convential coverage under FAC Rule 4-37.06 (10). This Rule allows for the issuance of policies other than those satisfying the prescribed minimum benefit standards if the policy is "either experimental in nature or demonstrated to be a type of coverage that will fulfill a reasonable need of a person or persons to be insured and is appropriately and prominently described in the [required] outline of coverage." There are no minimum benefits prescribed for non-convential policies.

Special Disclosures - FAC Rule 4-37.07 requires an outline of coverage containing prescribed information to be delivered at the time of application for a policy or at the time of delivery of the policy.

Definition of Facilities - FAC Rule 4-37.04 (2) defines convalescent nursing home, extended care facility and skilled nursing facility.

Massachusetts

Individual Accident and Health Regulations - Policies are governed generally by 211 Code of Massachusetts Regulation (CMR) 42.00 and 47.00.

Minimum Benefit Standards - Long-term care policies are treated as "restricted benefit health insurance" which is defined in 211 CMR 42.13 as accident and sickness insurance which does not meet the minimum standards prescribed for other coverages.

Minimum Loss Ratios - 211 CMR 47.09 (4)(g) provides "[F]or policies issued to those ages 65 or older, the minimum loss ratio shall be 65%, for those policies actually held by persons aged 65 or older".

Special Disclosures - 211 CMR 42.22 prescribes the content of a disclosure statement for restricted benefit health insurance. Section 42.14 requires the disclosure statement to accompany the policy or to be delivered at the time of application or by separate communication.

Definition of Facilities - 211 CMR 42.06 (3) contains a definition of a convalescent nursing home and skilled nursing facility.

New York

Individual Accident and Health Regulations - Policies are subject to regulation 62,11 New York Code of Rules and Regulations (NYCRR) 52, which governs all health insurance.

Minimum Benefit Standards - Long-term care policies are categorized as limited benefit health insurance which is governed by 11 NYCRR §52.10. No minimum benefits are prescribed for this category.

Minimum Loss Ratios - 11 NYCRR §52.45 (c) prescribes a 65% minimum loss ratio for individual insurance issued to persons over 65.

Special Disclosure - Under 11 NYCRR §52.54 every individual accident and health insurance policy must be accompanied by or must incorporate a prescribed disclosure form. The content of the disclosure forms for limited benefit health insurance is prescribed in 11 NYCRR §52.59. §52.59 conains separate requirements for policies issued to those under 65 and for those issued to persons 65 and older.

Pennsylvania

Individual Accident and Health Regulations - 31 Pennsylvania Code c.88 contains standards applicable to individual accident and sickness insurance policies.

MEDIGAP Regulations - According to the staff of the Pensylvania Department, if a rate filing indicates a policy is to be sold only to Medicare eligible people, it will be required to conform to the MEDIGAP standards. However, an insurer may avoid this treatment by filing rates for people under age 65.

Minimum Benefits - Long-term care policies are categorized as "supplemental insurance coverage" under 31 Pennsylvania Code §88.171. Supplemental insurance coverage is defined as providing benefits that are less than the minimum standards for benefits required for other coverages. The Rule allows such policies to be issued if a prescribed outline of coverage is completed and deliv-

ered. The policy title, the policy description or schedule page must clearly state that coverage is intended only to supplement other basic coverages.

Minimum Loss Ratios - 31 Pennsylvania Code §89.83 (b) prescribes a minimum loss ratio of 50% for all new filings other than industrial policies. §89.83 (c) requires revised rates to conform to a 60% standard.

Special Disclosures - 31 Pennsylvania Code §88.171 requires supplemental insurance policies to be accompanied by an outline of coverage prescribed by §88.195 and to clearly state that coverage is intended only to supplement other basic coverages.

Definitions of Facilities - 31 Pennsylvania Code §88.132 defines convalescent nursing home, extended care facility and skilled nursing facility.

Washington

Individual Accident and Health Regulations - Washington Administrative Code (WAC), chapter 284-50, regulates the advertisement of disability (i.e. health) insurance. Although characterized as a regulation governing advertisements, WAC 284-50 prescribes both the form and content of policies.

Minimum Benefit Standards - Long-term care policies are categorized as limited benefit health insurance coverage under WAC 50-370. Limited benefit health insurance is defined as any policy which provides benefits less than the minimum

standards prescribed for other coverages and which is approved as being in the public interest. The Rule also requires delivery of an outline of coverage as prescribed by WAC-50-425.

Minimum Loss Ratios - WAC 284-60-050 (1) establishes a 60% minimum loss ratio for individual disability policies. However, the WAC 284-60-90 allows for exceptions to be approved with satisfactory actuarial demonstrations. WAC 286-60-010 makes the loss ratio requirement applicable to all the forms filed after August 31, 1983 and to all previously approved forms as of January 1, 1985.

Special Disclosures - WAC 284-50-425 prescribes the content of the outline of coverage which must be used in connection with limited benefit health insurance. Under WAC 284-50-380 the outline of coverage must be delivered with the policy or delivered at the time the application is made.

Definitions of Facilities - WAC 284-50-315 (3) provides definitions for convalescent nursing homes, extended care facilities and for skilled nursing facilities.

Wisconsin

Individual Accident and Health Regulations - Wisconsin Administrative Code (WAC) s.Ins. 3.13 governs individual accident and sickness insurance.

MEDIGAP Regulations - WAC s.Ins. 3.46 (5)(c) requires that policies sold to Medicare eligible persons must meet the

disclosure requirements of WAC s.Ins. 3.39 (7)(b). Ins. 3.39 sets standards for disability insurance sold to Medicare eligible persons.

Minimum Benefit Standards - WAC s. Ins. 3.46 prescribes standards, including minimum benefit requirements, for nursing home insurance.

Minimum Loss Ratios - WAC s.Ins. 3.13 (6)(b)(3) requires policy form filings to be accompanied by an indication of the anticipated loss ratio on an earned-incurred basis. No minimum loss ratio is prescribed. Furthermore, s.Ins. 3.13 (6)(b)(4) excludes guaranteed renewable policies from the requirements that rate filings include an indication of the anticipated loss ratio.

Special Disclosures - WAC s.Ins. 3.39 (7)(b) requires nursing home policies sold to Medicare eligible persons to bear the following caption: "This policy's nursing home benefits are not related to Medicare. For more information see 'Health Insurance Advice for Senior Citizens' given to you when you apply for this policy."

Appendix 1.

Organizations Contacted with Respect to Long-term Care Insurance Regulation

1. American Association of Retired Persons-Cheryl Keany
2. American Council of Life Insurance-Vince Donnelly
3. American Health Care Association-Larry Lane
4. Blue Cross Association-Dave Strachan
5. Health Insurance Association of America-Purlaine Lieberman, Kim Bellard and John Mathews
6. National Association for Home Care - Dayle Berrce and Eileen Ales
7. National Association of Insurance Commissioners
8. National Citizen's Coalition for Nursing Home Reform - Elma Holder
9. National Council of Senior Citizens - Janet Myder
10. National Senior Citizens Law Center - Toby Edelman
11. U.S. Department of Health and Human Services - Mark Meiners (and David Kennell at ICF Inc.)
12. U.S. Senate Committe on Aging - Tricia Newman

Appendix 2.

Insurers Contacted

1. Columbia - Tom Mertz - (717) 784-2722
2. CNA - Dale Sink - Product Manager (Accident and Health)- (312) 822-5292
   Bill McGinley - Agent (609) 866-5999
3. Equitable - Lee Purrington - Underwriter - (801) 521-2500
4. Firemans Fund - Robert DeLue - Agency (415) 992-7000
5. Great Republic - Karen Adair - Marketing -(206) 285-1422
   Tish Bailey - Underwriting
6. Lumbermens (Kemper) - Chuck Majewski - Underwriter - (312) 540-2000
7. Mass. Indemnity - Rosetta Weintraub - Compliance - (314) 849-5555
   Ron Johnson - Agent - (612) 544-5441
8. Mutual of Omaha - John Houss - (402) 978-2292
9. Mutual Protective - Joe Sus - Compliance (402) 551-6900
   John Gamerl - Marketing -
10. National Foundation - Randy Riddell - Legal - (817) 878-3329
11. Penn Treaty - Larry Roscon - Marketing - (215) 437-9610
12. Sterling - Julie Fairbanks - Product Development (513) 328-2200
13. Transport Life - Ralph Evans - (817) 390-8908
14. United Equitable - Suzanne Cornick - Government Relations - (312) 677-4800
    Bill Foreman - Agent - (206) 454-8600
15. World Life - Joe Roetz - (215) 265-2200
    Bob Procor - Product Development

**HEALTH
INSURANCE
ASSOCIATION
OF AMERICA**

1025 Connecticut Avenue, N.W. Washington, D.C. 20036-3998 (202) 223-7780

August 18, 1986

The Honorable Claude Pepper, Chairman
Subcommittee on Health and Longterm Care
House Select Committee on Aging
3// House Annex II
Washington, D.C. 20515

Dear Chairman Pepper:

The purpose of this letter is to express some of the concerns of the commercial health insurance industry in response to charges made against the Medicare Supplement insurance business in your Subcommittee's report, "Catastrophic Health Insurance: 'Medigap' Crisis." The Health Insurance Association of America and its member companies feel that your charges that nearly one quarter of this business is "lost to waste and abuse" requires our comments, hopefully to change such statements through a greater illumination of the facts. Such charges are not correct in our opinion. At the same time, however, we would like to make it clear that our industry shares your concern for the social welfare of the elderly. Not only is it in our better interest to encourage sound business practices, but it has long been our goal to assure adequate health care protection to all Americans through the private sector. In fact, the HIAA has actively pursued laws which protect the elderly against sales abuse, assure minimum benefits, and maintain fair prices regarding Medicare Supplement policies. This has resulted in the adoption of laws and regulations in all 50 states designed to accomplish these goals.

Our primary concerns are listed below. These comments were prepared as a result of a recent meeting of the HIAA Medicare Supplement Task Force, the members of which represent the major commercial underwriters of Medicare Supplement insurance in the U.S.

o The Subcommittee report states that a substantial portion of Medicare Supplement premium dollars are "lost to waste and abuse", basing such findings solely on the fact that individual commercial Medicare Supplement policies have lower average loss ratios then group policies or those of Blue Cross/Blue Shield. To say that the difference between benefit payments and premiums received represents wasted policyholders' money lacks an understanding of commercial insurance industry practices in the conduct of their business. Commercial health plans are subject to policies and practices not placed upon or required for the Blues, such as state premium taxes and federal income taxes. Further, commercial insurers often reach a segment of the elderly population not eligible for group insurance or who otherwise do not opt for group or Blues coverage. To do so, these insurers must employ a sales force to market and maintain their products, also unlike the Blues, the expense of which adds to administrative costs. Commercial group health insurance policies return a greater proportion of premiums than do individual policies and are closer in terms of loss ratios to the Blues results.

Several important differences between group and individual policies create the heavier administrative cost burden for individual policies. The cost of acquiring individual business is greater in that commissions relate to a single insured, whereas group policies spread this administrative cost among all members of the group. Maintaining individual business is also more costly. Premiums are collected by billing individual policyholders as opposed to handling single payments from group business. Also claims are submitted by each individual on an ongoing basis rather than gathered and initially processed through the group policyholder.

Also the securing of a cross section of risks to guard against anti-selection (the tendency of persons with poorer than average health expectations to apply for insurance to a greater extent than do persons with average or better health expectations) is more difficult and hence more costly for individual insurance. Under individual insurance, the insurability of the individual is based on an analysis of questions asked the applicant and sometimes medical examinations. Even after all the work and expense has been

incurred, the applicant may decide not to purchase the policy. In contrast, group insurance secures a reasonable cross section of risks by merely requiring a high percentage (usually 75%) of the members of the group to participate before the group policy is made effective. Further, the group policy protects itself against anti-selection by the occasional person who refuses coverage when first eligible by requiring that person to furnish satisfactory evidence of good health if he or she applies at a later date.

Further, to imply that policies with 60 percent loss ratios constitute a bad buy for Medicare Supplement consumers ignores the fact that this is the nationally required level for individual policies and group certificates solicited on a direct mail basis (75 percent for group). This applies except in states where requirements exceed those adopted as the minimum required by Congress. (Connecticut, Massachusetts, Michigan, Minnesota, New Jersey, and New York have 65% minimum loss ratio requirements for individual lines.)

Finally, the explosive nature of health care costs, in general, has meant that insurers cannot project claims costs accurately. Therefore, a loss ratio that is too high can result in an unsound financial condition for the insurer, impairing its ability to pay future claims.

o The Subcommittee report loses sight of established and universally accepted federal and state requirements regarding the underwriting and sale of Medicare Supplement insurance. In keeping with the Baucus Amendment to the 1980 Social Security Disability Act (P.L. 96-265), the states now require Medicare Supplement policies to meet certain minimum standards, as follows:

1. Coverage of Part A coinsurance for Medicare eligible expenses for hospitalization from the 61st day through the 90th day in any Medicare benefit period.

2. Coverage of Part A coinsurance for Medicare eligible expenses incurred during use of Medicare's lifetime hospital inpatient reserve days;

3. Upon exhaustion of all Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 90% of all Medicare Part A eligible expenses for hospitalization for up to an additional 365 days.

4. Coverage of 20% of the amount of Medicare eligible expenses under Part B, subject to a maximum calendar year out-of-pocket deductible of $200 and a maximum benefit of $5,000 per calendar year.

Bear in mind that these are purely minimum standards, that many states have requirements beyond the Baucus minimums, and that insurance companies are not precluded from writing higher levels of coverage or additional benefits. In fact, the vast majority of plans exceed these minimum standards. For these reasons, the HIAA believes that Medicare together with the private health insurance industry are doing a good job in providing protection against the medical costs of catastrophic illnesses.

o The Subcommittee report arbitrarily assumes that the elderly are unable to judge the parameters of Medicare and Medicare Supplement policies and ignores federal and state measures to prevent consumer abuse. The Subcommittee report charges that Medicare Supplement insurance consumers are mislead to believe that such coverage will protect them against the costs of longterm custodial nursing home care. On the contrary, adequate requirements exist to caution consumers that this is not the case. Generally, the so-called Baucus and NAIC requirements center around what regulators, legislators, consumers, and industry developed as ways of preventing or limiting the potential of marketing abuse. The concept enacted under the Baucus Amendment was that a well-informed consumer offered the best opportunity to minimize fraud. We underscore that these efforts universally adopted for Medicare Supplement policies to date include:

1. An outline of coverage which includes disclosure of the lack of longterm care coverage.

2. The Buyer's Guide, which also discloses the lack of longterm care benefits under both Medicare and Medicare Supplement policies.

3. Required acknowledgement by the applicant of receipt of both of the above.

4. "Free look" - a period of time similar to a cooling off period where the purchaser can return the policy for full refund.

5. Labeling of non-Medicare Supplement policies, plus an expanded explanation of the disclaimer.

6. Simplified policies and certificates.

7. Prior state approval of all policies and rate approval in most states.

o The Subcommittee report claims that the Baucus requirements and state regulation have failed and that Medicare Supplement sales abuses persist are insupportable. Of all the data solicited from state insurance departments by the Subcommittee, little was disclosed regarding the volume of abuses uncovered and successfully prosecuted. In any case, every state clearly has sufficient legislative and regulatory authority to deal with sales abuses. Also, a 1983 study funded by HCFA on the effectiveness of state regulation of Medigap insurance found that duplicative coverage was rare. Further, of the millions of Medicare Supplement policies presently in force, we are aware of only a handful of alleged violations actually brought to the attention of HCFA. Upon investigation, HCFA has indicated that the majority of these cases have been closed because they did not warrant federal action. HCFA coordinates review of alleged violation of federal statutes together with the Federal Trade Commission and the Postal Service. The HIAA feels that this process is adequate and that no new federal regulatory activities are warranted.

The Subcommittee cites this same data as evidence that residual federal government oversight is ineffective. If this is true, and we feel that it is not, then we fail to understand how the Subcommittee can claim that total federal regulation of the Medicare Supplement business would be an improvement over state regulation. Certainly, the federal government has not eliminated Medicaid fraud. This is one of the many reasons that we continue to support state regulation of the business of insurance. State regulators are closer geographically to the consumer, and are generally responsive to voters in the state. It is hard to believe that the creation of a new federal agency in this time of such limited resources could even match the effectiveness of state regulation.

Finally, if abuses persist, state and federal government can only exercise appropriate authority when such abuses are brought to their immediate attention. The same holds true for our companies involved in the Medicare Supplement business and their ability to self-police against sales abuses. In its reports of both the late 1970's and currently, the Subcommittee has brought to light various cases of fraudulent sales practices (during testimony by HIAA witness Robert Shapland at the June hearing, Chairman Pepper indicated that the subcommittee had evidence that several companies "trained their agents in making fraudulent pitches to prospective clients"). The HIAA would like to offer our assistance in disciplining any companies or agents whose abuses the Subcommittee has documented. Certainly it is in everyone's best interest to prosecute such wrongdoers.

o The fact that 70 percent of Medicare beneficiaries use private supplement insurance to fill the program's ever increasing deductibles and co-payments attests to its success, not to its failure. According to a recent HIAA survey of pre-retirement age individuals, aged 50 to 64, the strong majority of those surveyed believe that it is necessary for people over 65 to have health insurance to supplement Medicare. Additionally, over half of those surveyed were not confident that the current extent of Medicare benefits would continue (a copy of our survey, "The Prime Life Generation", is attached for your information). Although the Subcommittee report finds that widespread abuses have persisted for years, and that Medicare Supplement policies have little real value, the fact is that such coverage has remained consistently popular and is seen as a necessary investment against the shortcomings of the Medicare program. Congress should be aware of such sentiment when considering proposals to replace private Medicare Supplement insurance with a federally prescribed program.

o The Subcommittee arbitrarily assumes that most or all hospital indemnity and "dread disease" (e.g., cancer) insurance is a waste of money to the consumer. Hospital indemnity and specific disease insurance should not be confused with Medicare Supplemental insurance. Such indemnity and specific disease policies are sold to both young and elderly consumers and are completely unrelated to Medicare.

The HIAA feels that elderly consumers should be able to purchase a variety of insurance products. Hospital indemnity policies are designed to be purchased as supplements to other health insurance coverage. These policies provide additional cash for medical and non-medical expenses incidental to hospitalization (which may not be covered by regular health insurance) and replace lost income due to such hospitalization. In this same vein, specific disease policies are intended to be purchased as a supplement to standard health insurance for the elderly. Specific disease policies should not be purchased as primary health coverage, because they only cover one or a few specific diseases. Consequently, it should not be considered unreasonable per se for an elderly person to have a basic Medicare Supplemental policy, a hospital indemnity policy and a cancer policy. Each individual should be able to determine for his or herself what is a reasonable purchase.

o The federal government does little or nothing to let the consumer know that they are not protected against longterm care costs under Medicare. Surveys by the American Association of Retired Persons have found that 80% of the elderly erroneously believe that longterm nursing home care is covered by Medicare. The HIAA Prime Life survey found that pre-retirement age individuals also are uninformed about government coverage of longterm care. Sixty-four percent could not give an answer when asked what proportion of longterm care costs are covered by Medicare. Among those who gave an estimate, it was widely believed that Medicare covers a substantial portion of these costs. Clearly then it is not just the aged who are confused about what Medicare does and does not cover. Those still working and active, who are planning ahead for their retirement health care needs, should be targeted with better information. We hope that the Subcommittee could assist in this consumer education effort.

o Proposals to expand Medicare benefits are not a practical solution to the catastrophic care problem because acute medical care expenses are not the usual cause of such expenses among the elderly. The real problem is chronic longterm care. Based on a recent study financed by the National Center for Health Service Research, for those aged who spent more than $2,000 out-of-pocket, 81 percent of their additional expenses were for nursing home care.

About four years ago, an HIAA Task Force was established to explore this issue. A report, "Long Term Care: The Challenge to Society", produced by the Task Force, is available from our Public Relations Division. In December 1984, an industry-wide conference was held to build on the task force report and to expose industry representatives to a range of longterm care issues from a variety of perspectives. In November 1985, the HIAA joined other national organizations representing the aged, providers and payers in sponsoring a national conference entitled: "Private Long Term Care Insurance - the Emerging Market." The proceedings of that conference are also available upon request.

Industry representatives have since participated in numerous conferences and hearings called to bring interested parties together to begin a broad based effort to resolve some of the problems inherent with this issue. In addition, individual companies are exploring and/or are entering into the private sector market for longterm care insurance.

In its deliberations, the HIAA Longterm Care Task Force has identified some of the problems associated with the development, administration and marketing of a longterm care product. These problems are not trivial and solutions are not easily achieved. As possible solutions are found, these products be tested in the marketplace to see whether or not they will work.

As noted, the commercial health insurance industry is involved in longterm care financing. For example, the Fireman's Fund has been test marketing such a program and now has 12,000 to 15,000 policies in force. Over the years, new sales have been modified to reflect experience and various state regulatory restrictions. Coverage is for maximum confinement of 4 years in a skilled nursing facility, a daily benefit of up to $70 and a 20 or 100 day elimination period.

The United Equitable Insurance Group has marketed some form of nursing home product since the mid '70s, and current policies in force exceed 60,000. Their original plan covered one year of skilled care, but their current plan covers 4 years of skilled care and up to 12 months of intermediate or custodial care at a reduced level of reimbursement. Recent entrants into this market are offering up to 5 years of coverage with no reduction for custodial care.

Longterm care may well be the major health policy issue in the coming decades. The health insurance industry and individual companies are exploring the problems and seeking solutions. Each venture into the marketplace provides the industry with additional information on the feasibility and viability of private extended care insurance programs. However, both government and private resources are required to meet current challenges and plan for the future needs of our expanding elderly population. We would ask you to note, however, that statements ignoring such private attempts or casting doubt on the motives of the private sector could well dampen future company involvement in the long term care insurance market.

The HIAA would like to thank you, Chairman Pepper, and Subcommittee staff for your efforts on this important health care issue and for the opportunity to respond to your report. We hope that the above information sheds additional light on the problems you discuss therein. As always, we remain ready and willing to respond further to any questions you might have, as well as to work with you in stamping out any existing Medicare Supplement sales abuses.

Sincerely,

Linda Jenckes

Linda Jenckes
Vice President, Federal Affairs

Michael D. Monette
Vice President & Counsel
Government Relations

Direct Dial
215-988-8355

August 19, 1986 Express Mail

Honorable Claude Pepper, Chairman
Select Committee on Aging
Subcommittee on Health and Long-Term Care
377 House Office Building, Annex 2
Washington, D.C. 20515

Re: "Catastrophic Health Insurance: The 'MEDIGAP' Crisis"
Public Hearing -- June 25, 1986

Dear Mr. Chairman:

Thank you for extending the June 25 hearing record for receipt of insurance industry comments. Since we did not receive notice of the hearing, we were not able to offer testimony regarding the Subcommittee Report. Therefore, we respectfully request that the comments contained herein be entered into and made a part of the hearing record.

INTRODUCTION

Colonial Penn Group, Inc. is a Delaware holding company with its headquarters and executive offices located in Philadelphia. Through its insurance affiliates, Colonial Penn has specialized in offering life, health, auto and homeowners products to older Americans on a nationwide basis, primarily by direct response marketing methods. It pioneered innovative Medicare supplement and nursing home coverage for the elderly. For this reason, Mr. Chairman, we share your concerns for the plight of the elderly and we applaud your tenacious vigilance in this regard.

THE REPORT

We have reviewed what appears to be a draft Report consisting of 276 pages including appendixes. Page 169 relating to your letter to HCFA Administrator Roper is missing. Although the remainder of the Report reveals no other inconsistencies in pagination, at least one critical Table is missing from Section V on state regulation: Table V concerning the number of health insurance complaints asked for in the 1983 Insurance Department Questionnaire. This Table should be located at page 92.

Notwithstanding these discrepancies, we are assuming that the final Report is substantially similar in content, conclusions and recommendations. For the reasons which follow, we respectfully disagree with most of the conclusions and recommendations, because we do not believe that there is credible support for them in the Report.

Baucus/Pepper Amendment. This landmark amendment to the Social Security Act (hereinafter referred to as "Baucus") was enacted into law on June 9, 1980, but was not effective as regulation until July 1, 1982. Consequently, the regurgitation of pre-Baucus events and alleged abuses throughout the Report is irrelevant. Only what has happened since July 1, 1982 is relevant. We refer to this period (July 1, 1982 to present date) as post-Baucus.

By definition, Baucus refers to specific health coverage which is intended to supplement Medicare. For lack of a better buzz-word, it also is called "Medigap." Baucus makes reference to the "NAIC Model Regulation to Implement the Individual Accident and Sickness Insurance Minimum Standards Act . . . as it applies to

medicare supplement policies" as the minimum standard for such coverage. The NAIC Model sets out the minimum, four-part standard as follows:

1) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through 90th day in any Medicare benefit period;

2) Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days;

3) Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of 90% of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional 365 days;

4) Coverage of 20% of the amount of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket deductible of $200 of such expenses and to a maximum benefit of at least $5,000 per calendar year.

Hospital indemnity, dread disease and long-term care coverage do not meet this definition; therefore, they are not and were never intended to be "Medicare supplement" coverages. To include them in this Report under the banner of "Medigap" is mixing apples with oranges and only serves to confuse and distort the issue. Consequently, the Report is fatally defective with these coverages included.

Alleged "Medigap" Abuses. Once the Report is stripped of pre-Baucus history, the following "alleged" abuses are quantified or alluded to:

- Twelve agent interviews during May and June of 1986, eleven of which were alleged abuses (pp. 76-79);
- Eleven cases of alleged abuse identified by HHS Secretary Heckler on July 15, 1985 (p. 167), but p. 177 states that the Department of HHS has identified only four cases;
- Three Medigap-related actions since 1981 reported by the Justice Department (p. 171);
- Three post-Baucus instances of alleged abuse reported by the Postal Inspection Service in a May, 1986 letter (p.174);
- 1983 questionnaire to Insurance Departments requesting (a) all accident and health complaints and (b) asking if the Department had ever heard of 22 different types of alleged sales abuse without asking for complaint counts and dates (Appendix A); and
- 1986 abbreviated questionnaire to Insurance Departments which asked about the same 22 types of abuse without quantity or date and requesting three undated case histories (Appendix B).

We submit that the above quantity and "documentation" of alleged abuses does not justify the conclusion on page 176 of the Report that: "Abuses persist in an unprecedented fashion when it comes to the sale of insurance in supplementation of Medicare." Eleven agent interviews; eleven or four HHS cases; three Medigap-related actions by Justice; three accounts of Postal Inspection Service actions and a misguided attempt to count all categories of A&H complaints filed with Insurance Departments in the 1983 questionnaire does not support the conclusion that unprecedented abuses persist.

Any attempt to quantify Insurance Department complaints should focus only on Medicare supplement complaints, not every conceivable type of A&H complaint. Even Medicare supplement "complaints" would include 50% or more general inquiries and other "complaints" which belong in the unjustified category. Consequently, the Report is far from credible in this regard.

Recommendations. Section VIII of the Report recommends Federal legislation based upon faulty conclusions: H.R. 4213 and H.R. 4287. Although the only alleged post-Baucus sales abuses mentioned in the Report related to agents, H.R. 4213 would impact primarily direct response sales. Yet, none of the ancient, interstate horror stories regarding so-called unregulated "mail order" insurance exists today to our knowledge. Every jurisdiction has some form of unfair trade practices act and/or an unauthorized insurers (long-arm) statute, not to mention a plethora of related regulations. Consequently, we do not believe there is any evidence in the Report which would justify direct response marketing legislation. Nevertheless, if legislation of this nature is deemed necessary, it should be consistent with Baucus, to wit: $25,000 or up to five years imprisonment, or both.

The Part C approach contained in H.R. 4287 would seem premature at best. The NAIC is currently working on long-term health care model legislation and regulation. Meanwhile, insurers are planning and testing this new and innovative coverage. Problems with over-utilization, anti-selection and so forth must be resolved. Otherwise, the claims expense of expanded, comprehensive coverage would present a premium affordability problem for the elderly. H.R. 4287 represents a Federal HMO approach which is ill-advised at the present time. We would suggest that industry be given a chance to develop long-term and catastrophic health care products. Federal legislation should be considered only as a last resort after all else fails.

SUMMARY

The major defects in the Report have been mentioned: too much history and not enough relevant, recent data to support the conclusions. We do not believe so-called "Medigap" abuses are persistent, rampant and pervasive or that state regulation is ineffective. If a study of hospital indemnity and dread disease coverage is needed, it should be done separately, not as part of a "Medigap" Report. Meanwhile, industry should be given an opportunity to develop long-term and catastrophic health care coverages.

Federal legislation would be premature at this time. It would be an overreaction to the exaggerated and ill-founded conclusions of the Report. If Medicare reform is deemed necessary, then so be it. The confusion and misunderstanding among the elderly is the direct result of Medicare, not industry sales practices. To blame the insurance industry for the shortcomings of Medicare would be a serious mistake. We recommend that the Report be withdrawn as defective for the reasons indicated.

Thank you for the opportunity to offer these comments for the record.

Respectfully submitted,

M. D. Monette

Michael D. Monette

MDM/p-jmk

cc: Subcommittee Members

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

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The Honorable Claude Pepper
Chairman, Subcommittee on
Health and Long-Term Care
Select Committee on Aging
House of Representatives
Washington, D.C. 20515

Dear Mr. Pepper:

Thank you for your letter of June 2, 1986. I am happy to provide answers to the questions raised therein regarding the implementing of P.L. 96-265. We have arranged the responses to correspond with the sequence of your inquiries.

- Subsection 1882(a) of the Social Security Act requires the Secretary to establish a program of voluntary certification for Medicare supplemental health insurance policies. To date, how many policies have been submitted to the Secretary for certification? How many of these policies have been certified? Please include a copy of an approved policy affixed with the Secretarial certification emblem, as well as copy of the official emblem itself.

  As you know, the Federal Voluntary Certification Program, established under section 1882(a), is applicable only in those States whose legislative/regulatory program is determined not to meet the standards contained in the Federal law. The law provides that this determination be made by the Supplemental Health Insurance Panel (Panel) comprised of the Secretary of Health and Human Services and four State Commissioners of Insurance appointed by the President. Since the Panel has granted approval to 46 States, plus the District of Columbia and Puerto Rico, the Voluntary Certification Program is only applicable in Massachusetts, New York, Rhode Island and Wyoming, which have not received Panel approval. The limited applicability of the Federal certification program is a measure of the success of P.L. 96-265 in encouraging the vast majority of States to adopt meaningful legislation regarding the sale and marketing of Medicare supplement (Medigap) policies.

  To date, only two policies have been submitted to the Secretary for certification under the Voluntary Certification Program. Both submissions were returned because they required additional actuarial information. Neither were resubmitted for review. Therefore, no policies have been approved nor have any been authorized to use the Federal emblem. As requested, a copy of the official emblem is enclosed.

- Subsection 1882(b) of the Social Security Act states that any Medicare supplemental health insurance policy in any State which the Supplemental Health Insurance Panel determines has established under State law a regulatory program that meets certain requirements shall be deemed to meet the voluntary certification standards. How many States have been determined by the Secretary to meet these regulatory standards? What specific actions did HCFA take to determine initially whether each State's regulatory program met the specified criteria? What specific ongoing review does HCFA perform to determine State's maintenance of the regulatory programs?

  The Panel met several times during the years 1980-1983 to review the statutory and regulatory programs of the various States with regard to Medicare supplemental health insurance. As stated earlier, 48 States and the District of Columbia and Puerto Rico have been determined by the Panel to have programs which meet or exceed the requirements of P.L. 96-265. The four States determined by the Panel not to have approved programs are Massachusetts, New York, Rhode Island and Wyoming.

  In September 1980, the "Medigap Operations Staff" (MOS) was organized within the Bureau of Program Operations, HCFA and acted as staff support to the Supplemental Health Insurance Panel which made the official determinations. As part of its staff responsibilities, the MOS obtained copies of all State insurance legislation and regulations and, in

some cases, visited State Insurance Departments to resolve regulatory issues.

MOS then compared the State legislation/regulation with the benchmarks contained in the Federal legislation and made recommendations to the Panel. Panel actions took the form of approval, conditional approval, (usually pending the official adoption of State regulations) or disapproval. By June 1984, 46 States, the District of Columbia and Puerto Rico had approved programs.

In line with the Panel's responsibility to monitor the continued compliance of State programs with section 1882 standards, States are required to submit an annual written certification that no changes have been made to their legislation or regulations which would adversely affect their continued compliance. Where changes occurred HCFA reviewed these changes and made new recommendations to the Panel. To date, this recertification process has not resulted in any State losing its approved status.

- Subsection 1882(f) of the Act requires the Secretary to conduct a comprehensive study and evaluation of the comparative effectiveness of State approaches to the regulation of Medicare supplemental health insurance policies. It requires that the Secretary submit to the Congress no later than January 1, 1982, a report on the results of this study. This subsection also requires the Secretary to submit to the Congress no later than July 1, 1982, and at least every 2 years thereafter a report evaluating the effectiveness of the certification procedure and the criminal penalties established under section 1882. To date, has the Secretary submitted to the Congress those completed reports? If he has not, what progress has been made towards completion of each report? What specifically has caused these long delays?

  The study of the comparative effectiveness of State approaches to the regulation of Medicare supplement health insurance policies has not been submitted to the Congress. Surveys of Medicare beneficiaries and of insurance companies concerning several different types of health insurance were conducted in 1982 and 1983, and a draft report incorporating the survey findings was prepared in early 1985. As a result of initial delays in clearance, it has been necessary to update some of the information contained in the report. We are currently reviewing the report and plan to submit it to the Congress as soon as possible.

  With respect to the report evaluating the effectiveness of the certification procedure and the criminal penalties established under section 1882, the Bureau of Program Operations, HCFA, has prepared this report for inclusion in the Medicare Annual Report to Congress for every year since 1982.

- Through 1984 HCFA maintained a "Medigap Operations" staff within its Bureau of Program Operations. What was the reasons for its dissolution? How many staff (in FTEs) has HCFA dedicated to the administration of Medigap activities in fiscal years 1981-1986? How many are planned for fiscal year 1987?

  The Medigap Operations Staff was formed in 1980 to implement P.L. 96-265. By early 1981, it was staffed by four professional and two clerical employees. By 1983, there were eleven professional and three clerical employees. In January 1984, the staff was reduced to five Full Time Equivalencies (FTEs). By 1985, the bulk of the staff's work, the review and analysis of State regulatory programs, was completed. Since the Voluntary Certification Program was effectively eliminated due to the adoption of approved regulations by the vast majority of States, the remaining workload consisted primarily of liaison activities with regard to the complaint handling process. It was therefore determined that the remaining workload was insufficient to retain a separate staff and the work was assigned to another functional area in the Bureau of Program Operations. We estimate our staff resource needs to be one-half FTE for fiscal year 1987.

If we can be of further assistance, please let us know.

Sincerely,

William Roper

William L. Roper, M.D.
Administrator

Enclosure

Certified policies meet or exceed Federal standards for health insurance to supplement Medicare. YOU ARE NOT REQUIRED TO PURCHASE THIS OR ANY OTHER POLICY IN ORDER TO RECEIVE MEDICARE BENEFITS.

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The Mutual of Omaha Companies ■ International Headquarters: Mutual of Omaha Plaza, Omaha, Nebraska 68175

Mutual of Omaha Companies

July 2, 1986

The Honorable Claude Pepper, Chairman
U.S. House of Representatives
Select Committee on Aging
Subcommittee on Health and Long-Term Care
715 House Office Building Annex 1
Washington, DC 20515

Dear Congressman Pepper:

This letter is to thank your subcommittee for the opportunity to contribute to the examination of the insurance problems facing the elderly that was the subject of your hearing June 25, 1986. It was a pleasure to represent the Health Insurance Association of America before your subcommittee because of our joint concern for the welfare of the elderly. In fact, the HIAA has actively pursued laws which protect the elderly against sales abuse, assure minimum benefits, and maintain fair prices regarding Medigap policies. This has resulted in the adoption of laws and/or regulations in all 50 states designed to accomplish these goals.

During our discussions, a question was raised regarding the number of states which: 1) require delivery of the "Buyer's Guide" and "Outline of Coverage", 2) have adopted NAIC minimum benefit standards, 3) have adopted minimum loss ratio standards, and 4) approve premiums vs. have "file and use" laws.

On returning to Omaha, I requested research of these questions and we have determined that every state requires:

1) An outline of coverage which includes disclosure of the lack of long-term care coverage.

2) Delivery of the Buyer's Guide (which includes disclosure regarding the lack of long-term care benefits under Medicare and Medigap).

3) Acknowledgement by the applicant of receipt of #1 and 2.

4) Minimum benefits under Medigap policies.

We also determined that all states have minimum loss ratio standards applicable to Medigap policies.

Regarding the state rate approval process for Medigap policies, several things are involved. There are requirements that insurers submit premium rates, requirements that these submissions be approved or placed on file, and provisions that such rate filings are "deemed" approved if not disapproved by the insurance department within a given number of days.

In most states, we interpret the requirement that rates be "placed on file" as being the same as requiring that they be approved. This is because those states do not consider rates as being "placed on file" until they are officially approved. In some states with this requirement, we merely wait until we are notified that the rates have been place on file because this does not involve a review and approval process. Further, we view the provision that rates are deemed approved if disapproval is not given within a stated number of days as being different than "file and use" laws. Under casualty insurance "file and use" laws, there is a general understanding that state insurance departments are not taking an active role in the approval of premium rates and are instead depending on the competitive forces of the marketplace to control the reasonableness of premiums. Under health insurance where rates are deemed approved if not disapproved within the stated number of days, most insurance departments are taking an active role in reviewing premium rates. It would be impractical in this situation for insurers to use submitted rates when they did not receive official disapproval in the stated number of days. This is because of the disruption, confusion, and

costs involved in rolling back a rate change that was later disapproved. Therefore, our Company does not implement premium increases when the "deemer" time period runs out.

Given this background, Alaska is the only state that doesn't require submission and filing of rates. Some of the other 49 states require rate filing for informational purposes only while the majority actively review and approve rate submissions.

Congressman Pepper, we applaud your subcommittee's interest in attaining insurance coverage for the elderly to protect them against long-term care costs and would be delighted to work with you toward a solution. The HIAA has been studying this question for several years in conjunction with other organizations and has many ideas to contribute toward a final resolution of the problem. The tremendous costs involved, the impact of life care centers, questions regarding the use of community-based care alternatives to institutional care, etc., impact on the solution. Public policy regarding whether taxpayers should support the wealthy in passing on their assets to their heirs and other questions regarding the allocation of the cost for this protection are also involved. Some restructuring of Medicaid eligibility and tax incentives for the near-poor to purchase insurance could also be involved. All of this means that the solution may be a complex one.

Finally, we wholeheartedly support your thought that insurance should be available to everyone. The HIAA has taken a leadership role and has helped developed bills which are pending in both the House (H.B. 4742) and the Senate regarding the development of state uninsurable risk pools. We look forward to your active support of this legislation.

Congressman Pepper, I ask that you consider adding this letter to the hearing record so that future deliberations begin with accurate information regarding the Medigap protective system already in place.

Respectfully submitted,

Robert B. Shapland
Vice President and Actuary
Mutual of Omaha Insurance Company

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